

041751 JAN 21-87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7

REG. NO.

0 2 1 0 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>THERESA MARY ALLEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1/21/87</b>			2b. HOUR <b>10<sup>00</sup></b> A M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 4, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS <b>10 00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Fallston</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GEN HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Edgemere</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>-2124 Lodge Forest Dr. 21222</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph DeKowski</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Not Known</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-38-8637</b>		17. INFORMANT ADDRESS <b>Joseph P. Allen 2124 Lodge Forest Dr.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADULT RESPIRATORY DISTRESS SYNDROME</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HEMOPHILUS INFLUENZA PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b>DIABETES MELLITUS, CEREBRO-VASC. INSUFFICIENCY, COPD</b>									
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. — 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>—</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET <b>—</b>		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) <b>(did not)</b> attended the deceased from <b>1/13/87</b> to <b>1/21/87</b> , that (I) <b>(lost)</b> saw the deceased alive on <b>1/20/87</b> , and that in (my) <b>(lost)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(did not)</b> view the body after death.									
27b. SIGNATURE <b>David R. Padrino, M.D.</b>				DEGREE <b>M.D.</b>				27c. DATE SIGNED <b>1/21/87</b>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID R. PADRINO, M.D.</b>				27e. ADDRESS <b>1212 Churchville Rd., Bel Air 21014</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-24-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill</b>		23d. LOCATION CITY OR TOWN <b>Baltimore, Maryland</b>		COUNTY	STATE
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Funeral Home of Dundalk</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Ruck</b>			
25c. ADDRESS <b>7922 Wise Ave. Dundalk, MD 21222</b>									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a coroner's inquest held.

BP



FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 0 2 1 0 2  
REG. NO.

1. DECEASED NAME (SPELLED CORRECTLY) Walter Hardin Amos			2a. DATE OF DEATH MONTH DAY YEAR 1 26 87			2b. HOUR 10 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 7, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) chauffeur		12b. KIND OF BUSINESS OR INDUSTRY Trucking	
13a. STATE N. Carolina			13b. COUNTY Guilford		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 923 Plantation Farm Rd.			14. FATHER'S NAME FIRST MIDDLE LAST Jesse Amos			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Meeks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) XXXXX Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Eden, N. Carolina 27288 Fair Funeral Home, P.O. Box 337				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Pulmonary Carcinoma / Chronic Obstructive Lung Disease</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that this (this hospital) attended the deceased from 1/26 1987 to 1/26 1987, that (we) last saw the deceased alive on 1/26 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) signed and view the body after death.									
22b. SIGNATURE <u>George Laws MD</u>					DEGREE M.D.		22c. DATE SIGNED 1-26-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Laws MD					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 29, 1987		23c. NAME OF CEMETERY OR CREMATORY Overlook		23d. LOCATION CITY OR TOWN COUNTY STATE Edner, Rockingham N.C.		
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214					25a. DATE REC'D. BY REGISTRAR JAN 28 1987				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "I have" and "to" are faintly visible.]*



040673 JAN 16 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

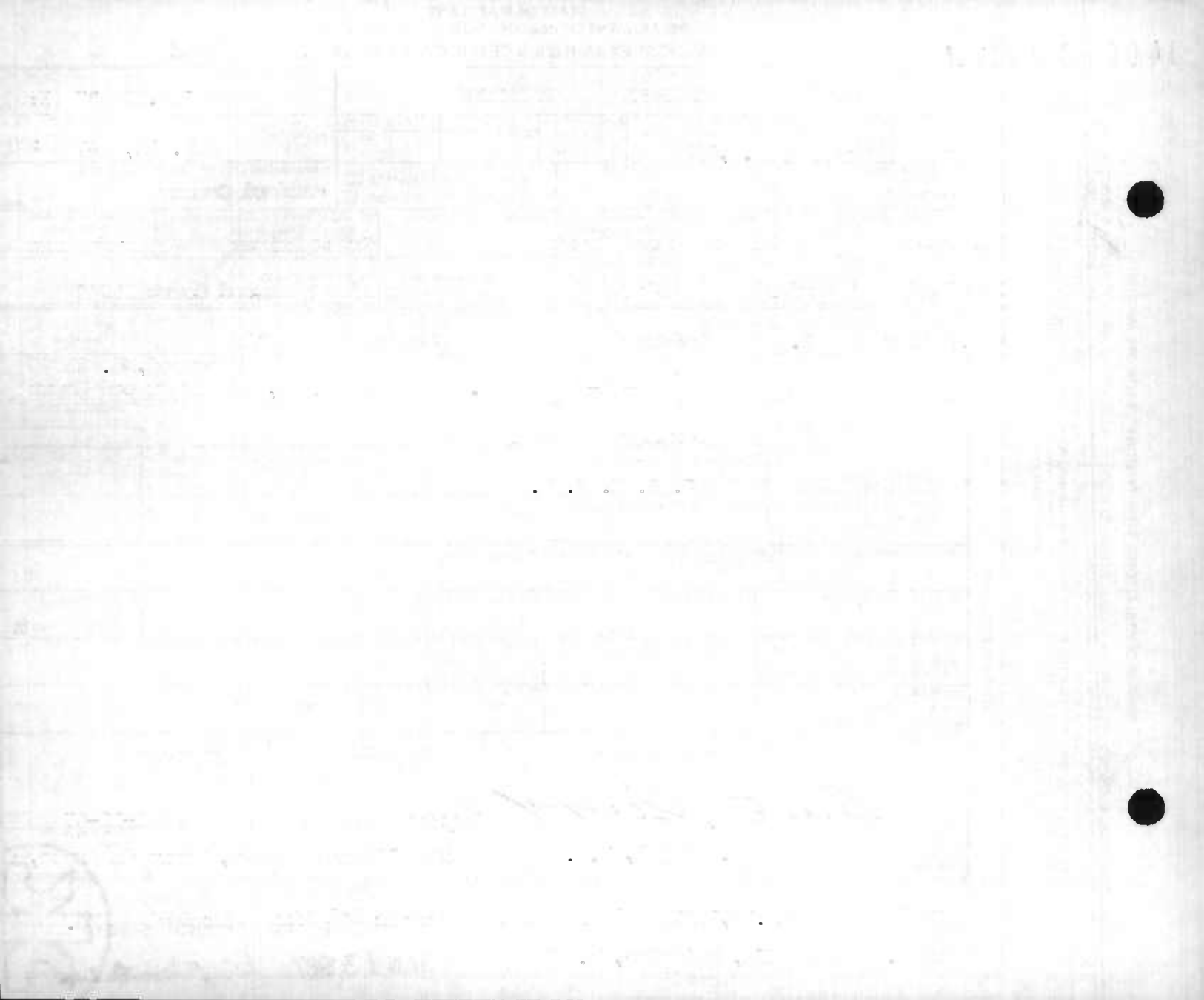
BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02103

1. DECEASED NAME (TYPE OR PRINT)		FIRST NORMAN		MIDDLE CARROLL		LAST ANDERSON		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Jan. 12, 1987		2b. HOUR 3:00 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Jan. 12, 1987		2d. HOUR 9:00 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Edgewood		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 325 Crestwood Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Manufacture			
13a. STATE Maryland		13b. CITY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 325 Crestwood Court 21040			
14. FATHER'S NAME FIRST MIDDLE LAST William A. Anderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Ella Morris				16. ADDRESS Edgewood, Md. 21040			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		217-24-5066		17. INFORMANT N. Elizabeth Harmon, 325 Crestwood Court					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>A. S. C. V. D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Luis E. Renjel</i>		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				DATE SIGNED 1-12-87 21078					
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.		ADDRESS 464 Alliance Street, Havre de Grace, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.					
24. FUNERAL DIRECTOR NAME Howard K. McComas III,		ADDRESS Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR JAN 13 1987		25b. REGISTRAR'S SIGNATURE <i>John L. ...</i>					



042780 FEB-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL WITHIN 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFERMENT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02104

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
		NANCY LEE ATKINSON					1-19-87 <sub>19</sub>		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
FEMALE	White	DEC. 8, 1942		44 YRS.			1-19-87 <sub>19</sub>		1:25P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Baltimore Maryland		U.S.A.				Harford County MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Fallston (21047)		Fallston General Hospital				Secretary		Office		
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Maryland		Harford Co.		Bel Air				1417 Wabash Drive 21014		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
LEROY WILHELM					MAZIE MILLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT (NAME AND ADDRESS)			
NO					212-40-6739		Mr. Joseph R. Atkinson 1417 Wabash Drive Bel Air, Maryland 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Acute carbon monoxide intoxication										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 1-19-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
							subject inhaled exhaust fumes from car			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN STATE			
					garage		1417 Walbash Drive Bel Air, Maryland			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE					TITLE (SPECIFY)					DATE SIGNED
Margarita A. Korell, M.D.					Assistant MEDICAL EXAMINER					1-20-87
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS					
Margarita A. Korell, M.D.					111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		January 22, 1987		Mt Zion Meth. Chur Cemetery		Bel Air, Harford Co. Maryland				
24. FUNERAL DIRECTOR		25. REGISTRAR'S SIGNATURE								
Joseph William Foster		JAN 23 1987								
50 W. Broadway & Williams Sts Bel Air, Maryland 21014										



040136 JAN - 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

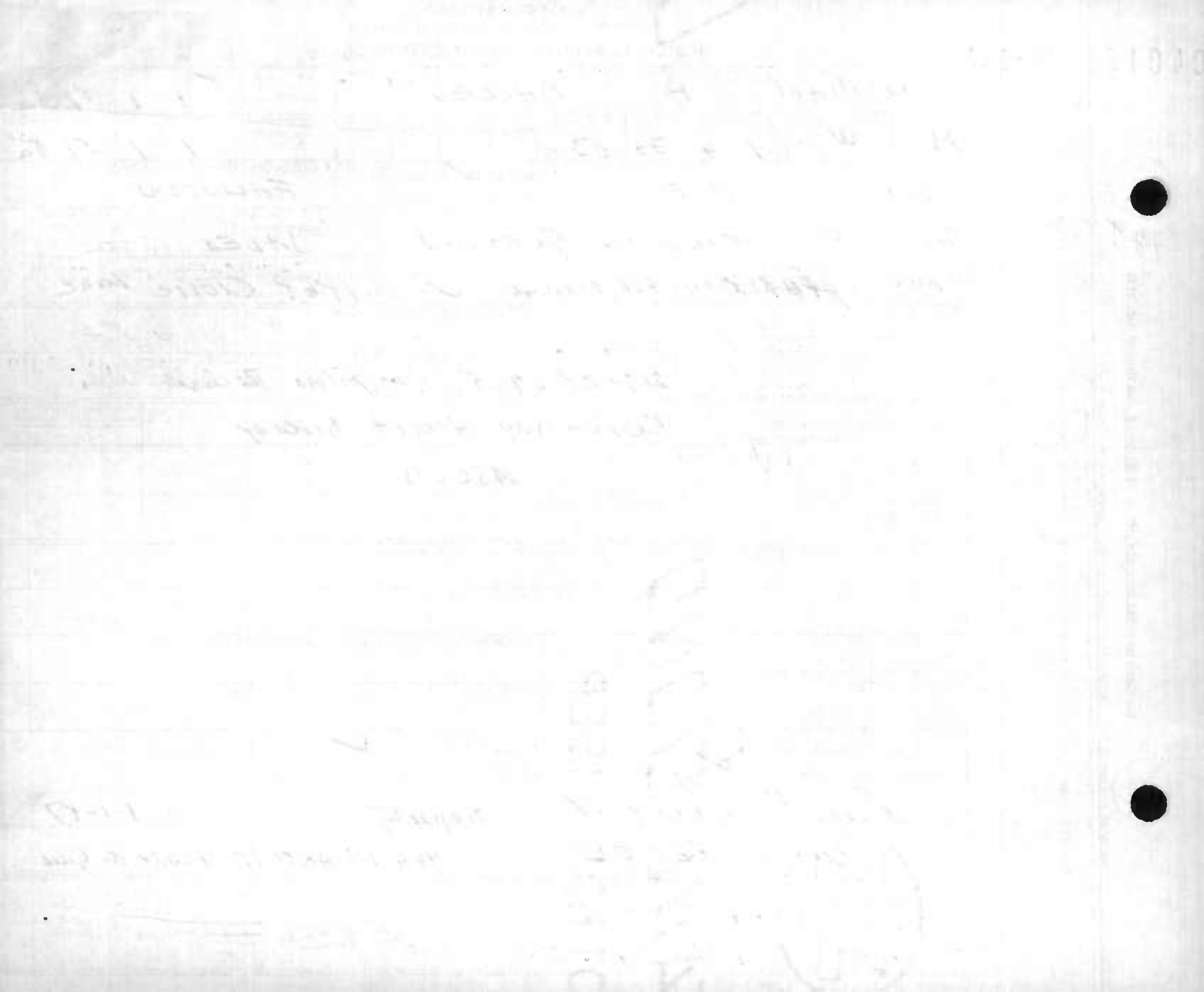
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC'D NO 2105	
1. DECEASED NAME (TYPE OR PRINT) FIRST William MIDDLE Hartley LAST Bailey, Jr.						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 1 1 19 87		2b. HOUR 8:30 M			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 4 33 03 YRS.		6. AGE (IN YEARS) LAST BIRTHDAY 03 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 1 19 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH FALLSTON Harford MD					
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON General				12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY Lumber			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE MD					
13b. CITY OR TOWN FALLSTON		13c. CHURCH OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1868 Eloise Lane 21040					
14. FATHER'S NAME FIRST William MIDDLE Hartley LAST Bailey, Sr.						15. MOTHER'S MAIDEN NAME FIRST Elsie MIDDLE I LAST Mitchell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea 213-28-1907		17. INFORMANT Susan D. Bailey		ADDRESS Edgewood, Md. 21040 1868 Eloise Lane,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF ASCVD. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Luis E. Renjel				TITLE (SPECIFY) Deputy				DATE SIGNED 1-1-87			
EXAMINER'S NAME (TYPE OR PRINT) LUIS E. RENJEL				ADDRESS 464 ALLIANCE ST Harford							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 5, 1987		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cecil Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009						25a. DATE RECEIVED BY REGISTERAR JAN 5 1987		25b. REGISTERAR'S SIGNATURE Julia B. Baker			

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 02100

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>GOLDIE D. BRILL</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 17 87</i>			2b. HOUR <i>9:55 PM</i>			
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>SEPTEMBER 16, 1908</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VIRGINIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford MD.</i>			
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>(RET) WAITRESS</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>DINER</i>	
13a. STATE <i>MD.</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Havre de Grace</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>129 Bloomsbury Ave. 21078</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>JAMES HARRISON ROSENBERGER</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>BESSIE EWING</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>225-12-2907</i>		17. INFORMANT ADDRESS <i>MELVIN R. BRILL, 129 BLOOMSBURY AVE, HAVRE de GRACE, MD</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12-28</i> 19 <i>86</i> , to <i>1-17</i> 19 <i>87</i> that (I) (we) lost saw the deceased alive on <i>1-17</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above) (if true) (and did not) view the body after death.							

22. SIGNATURE *[Signature]* DEGREE *[Blank]* ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐  
22b. DATE SIGNED *1/21/87*

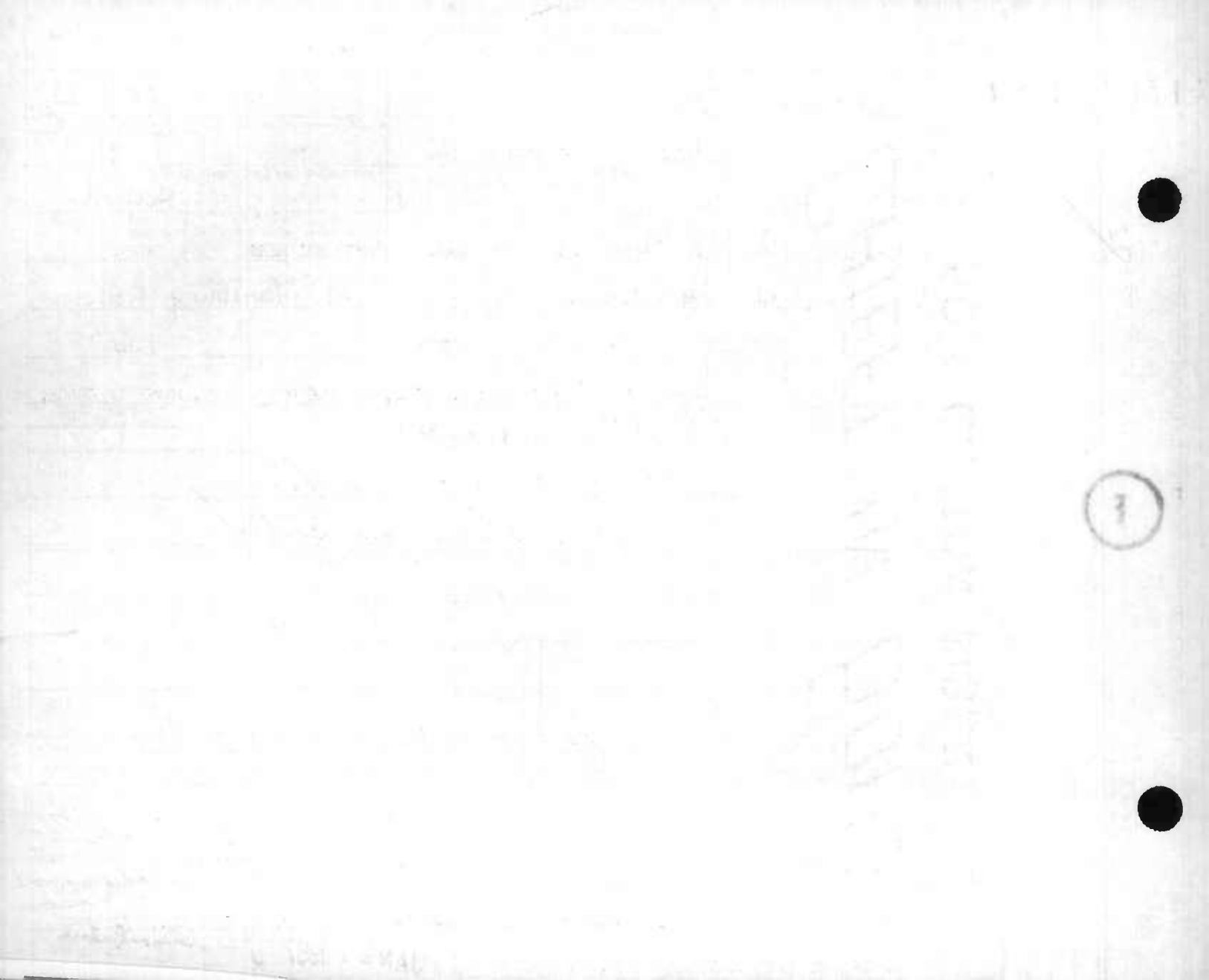
22c. PHYSICIAN'S NAME (TYPE OR PRINT) *Dr. ANNA KROWN K.D. 319 S. Union Ave. Havre de Grace MD 21078*  
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>21 JANUARY 87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HARFORD MEMORIAL GARDENS</i>		23d. LOCATION CITY OR TOWN COUNTY <i>ALDINO, HARFORD CO., MARYLAND</i>	
24. FUNERAL DIRECTOR NAME <i>MITCHELL FUNERAL HOME, HAVRE de GRACE, MD 21078</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 21 1987</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





040054 JAN 68

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02101  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Willie L. BRYAN</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1-1-87</i>		2b. HOUR <i>4:00 PM</i>		
3. SEX <i>MALE</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6 29 10</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS HOURS MIN. <i>76</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.	
10. CITY OR TOWN OF DEATH <i>Fallston</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>MD</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>street</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Edgar BRYAN</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNK</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>217-14-3359</i>	
17. INFORMANT ADDRESS <i>Ernestine Beasley 518 Ohio St Md</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ischemic heart disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			

## MEDICAL CERTIFICATION

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>C.O.P.D.</i>			
19a. DATE OF OPERATION <i>1-1-87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— P.M. 19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i>		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>— — — —</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>12</i> 19 <i>85</i> , to <i>1-1</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>12</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, please state date and hour when you last saw the body after death.)			
22a. SIGNATURE <i>Robert A. Duncan MD</i>		22b. ADDRESS <i>1131 Bel Air Rd</i>	
22c. DATE SIGNED <i>1-1-87</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-6-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Taber nace</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Fallston Harford Md</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>ARNOLD BEARD Havre de Grace Md</i>		25a. DATE REC'D BY REGISTRAR <i>JAN 6 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Stedman</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.



041168

JAN 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

02

08

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MAUDE ROSELLA BRYANT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 11, 1987</b>		2b. HOUR <b>12:30 A.M.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 17, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Hartford County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Fallston (21047)</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2303 Hartford Road</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Practical Nurse</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Hartford Co.</b>	13c. CITY OR TOWN <b>Fallston (21047)</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2303 Hartford Road 21047</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Oliver Bollinger</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>ELLA Baublitz</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-05-4755</b>		17. INFORMANT (Daughter) 877-7295 ADDRESS <b>Mrs. ELAINE B. Edwards 2303 Hartford Road Fallston, Maryland 21047</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>End Stage Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Andrew Nowakowski MD</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/12/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREW NOWAKOWSKI MD</b>			22e. ADDRESS <b>125 N. MAIN ST. BEL AIR, MD 21014</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JANUARY 13, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		23e. DATE RECEIVED BY BUREAU OF REGISTRATION <b>JAN 14 1987</b>			
24. FUNERAL DIRECTOR <b>Joseph William Foster 50 W. Broadway &amp; Williams St. Baltimore, Maryland 21014</b>		25. REGISTRAR'S SIGNATURE <b>Julia Dendron-Randall</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the Registrar. Page 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

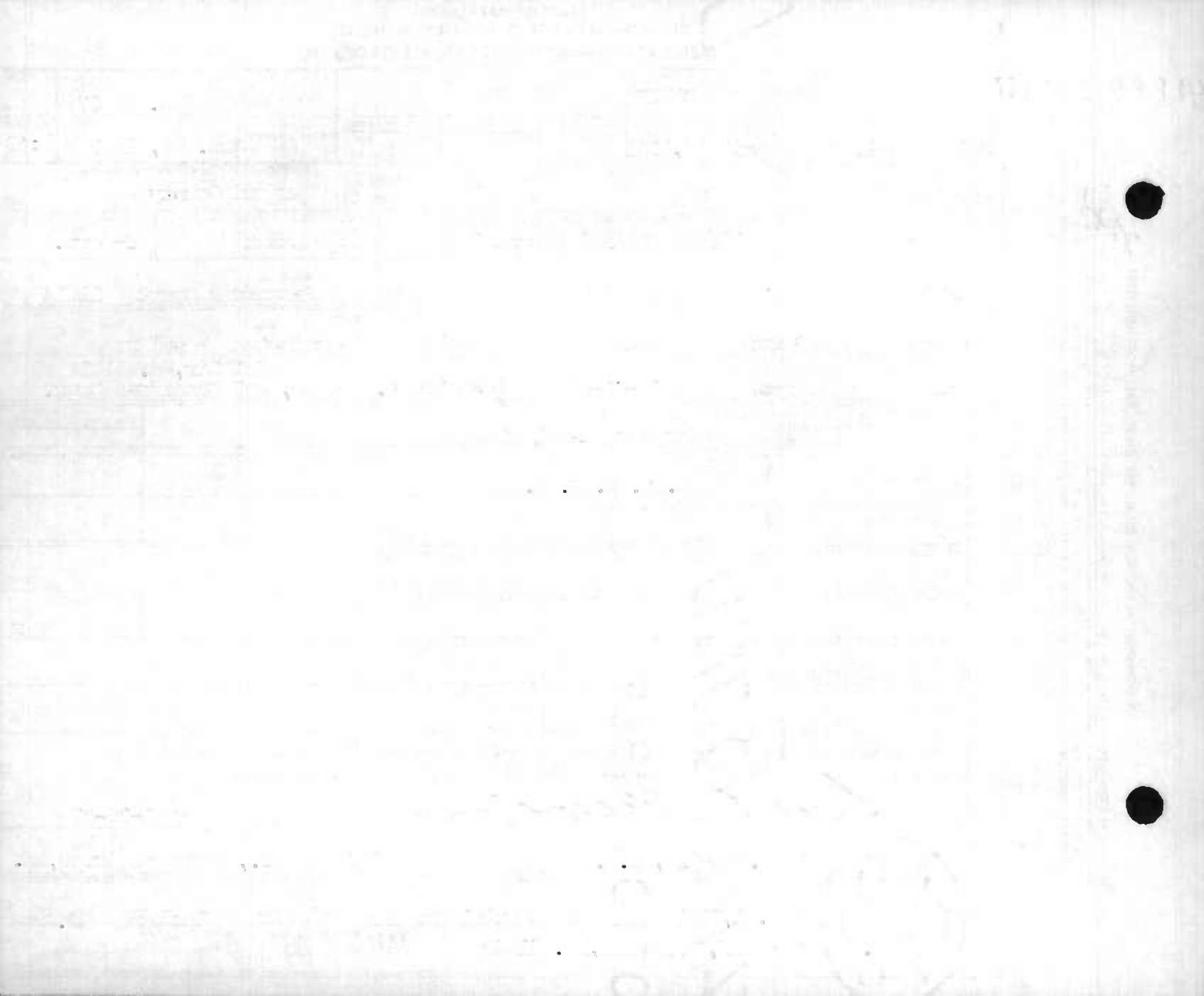
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOV 17 1940



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02109	
1. FOR STATE REGISTRAR											
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT DAVID BURGER										20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Jan. 20, 1987	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 10, 1943		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 43		7. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		21. DATE PRONOUNCED DEAD Jan. 20, 1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County	
10. CITY OR TOWN OF DEATH Fallston				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY US-Govt.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 405 Sassafras Court 21014			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Charleson Burger						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Antoinette Dolar					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 215-42-0325		17. INFORMANT ADDRESS Carolyn L. Burger, 405 Sassafras Court Bel Air, Md. 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) A. S. C. V. D. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Luis E. Renjel				TITLE (SPECIFY) Deputy				DATE SIGNED 1-20-87			
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.				ADDRESS 464 Alliance St., Havre de Grace, Md. 21078							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 23, 1987		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.	
24. FUNERAL DIRECTOR Howard K. McComas III, DRES						25a. DAY RECEIVED BY REGISTRAR JAN 27 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			



040137 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02110

1. DECEASED NAME (TYPE OR PRINT) <b>Phyllis</b>		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>1 3 1987</b>				2b. HOUR <b>1:02 PM</b>			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 11, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>1 3 1987</b>		7d. HOUR <b>1:02 PM</b>			
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.			
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HARFORD MEMORIAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>				12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE <b>MD</b>		13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>Aberdeen</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>16 E AZTEC ST. 21001</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOLA ESTELLE KNIGHT</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>220 14 2743</b>				17. INFORMANT <b>JOHN W. BURKENTINE</b>				SAME AS #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>Luis E. Renjel</b>				TITLE (SPECIFY) <b>M.D. DEPUTY</b>				DATE SIGNED <b>1-3-87</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>LUIS E RENJEL</b>				ADDRESS <b>464 Alhambra St</b>				MEDICAL EXAMINER <b>Havre de Grace</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>6 JANUARY 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEL AIR MEMORIAL GARDENS</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>BEL AIR, HARFORD COUNTY, MARYLAND</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MD 21078</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1987</b>				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 2 1 1 1  
REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELBERT N. CALDWELL			2a. DATE OF DEATH MONTH DAY YEAR 01 10 87			2b. HOUR 9:15 PM			
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR JAN 31 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD CTY MD.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service		12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md				13b. CITY OR TOWN CONOWINGO		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE Millers Trailer Park 21918	
14. FATHER'S NAME FIRST MIDDLE LAST John Caldwell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Parks		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII					
16b. SOCIAL SECURITY NO. 203-07-8049		17. INFORMANT ADDRESS Leonard Caldwell, Peach Bottom, Pa.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER Shwck DUO TO, OR AS A CONSEQUENCE OF (b) MASSIVE Anterolateral wall MI. 2 day DUO TO, OR AS A CONSEQUENCE OF (c) ADAM Adult onset DIABETS MELLITUS. YEARS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. ASCVD									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1/9			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1/10 19 87			
22a. I certify that (I) (this hospital) attended the deceased from 1/10 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Barry Wohl			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-10-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY WOHL			22e. ADDRESS 1315 Union Avenue Havre de Grace, Md 21078						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/14/87		23c. NAME OF CEMETERY OR CREMATORY CONOWINGO Baptist		23d. LOCATION CITY OR TOWN COUNTY STATE Conowingo Cecil Md		
24. FUNERAL DIRECTOR NAME Joe Reynolds			ADDRESS 144 E. State St., PARRVILLE, PA			25a. DATE REC'D BY REGISTRAR JAN 19 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

3

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02112  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Frederick F. Clark</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 18 87</b>			2b. HOUR A M <b>1045 A M</b>			
3. SEX <b>m</b>		4. RACE <b>w</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 21 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.			
10. CITY OR TOWN OF DEATH <b>Harford</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machanist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Electric Co</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Rising Sun</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>64 Louise Court 21911</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin F. Clark</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene Ford</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>165030881</b>		17. INFORMANT ADDRESS <b>Mary F. Clark 64 Louise Court</b>		17. INFORMANT ADDRESS <b>Rising Sun, MD 21911</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) Cerebral Infarct.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal failure, Pul. edema.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>(neurogenic).</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-18</b> 19 <b>87</b> , to <b>1-18</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>1-18</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>B. Parekh</b>			DEGREE <b>MD.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-18-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. PAREKH MD.</b>			22e. ADDRESS <b>1908 HARFORD RD, FALLSTON MD 21047</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-22-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosebank Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Calvert Cecil MD</b>		
24. FUNERAL DIRECTOR NAME <b>R.T. Foard Funeral Home</b>			ADDRESS <b>Rising Sun MD</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandora</i>	

20% COTTON FIBRE

042006 JAN 29

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 02115

1. DECEASED NAME (TYPE OR PRINT) Bynum Dale Cockerham			2a. DATE OF DEATH MONTH DAY YEAR 1-18-87			2b. HOUR 8 36 PM			
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7 06 20		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland			13b. CITY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Elbert Cockerham			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Emo Jones			13e. STREET ADDRESS / ZIP CODE 3508 Clayton Road 21085			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-26-9898		17. INFORMANT ADDRESS Minerva M. Cockerham same as above					
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest. Possibly →</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction or stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recent hemorrhagic stroke (11/28/86) right 11/28/87</u> RECENT HEMORRHAGIC STROKE (11/28/86) right 11/28/87 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT BELIEVED TO BE A TERMINAL DISEASE OR CONDITION AT THE TIME OF DEATH <u>Rever. of unknown etiology, multiple Sclerosis x 15 yrs</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 36 PM	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE 1800 Harford Rd. Fallston, MD 21047					
22a. I certify that (1) this individual attended the deceased from saw the deceased about <u>Jan 18, 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) was (did) (did not) view the body after death.								22b. DATE SIGNED Jan. 19, '87	
22c. SIGNATURE Albert S. C. Sun, M.D.				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S. C. Sun, M.D.				22e. ADDRESS 1800 Harford Rd. Fallston, MD 21047	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/21/1987		23c. NAME OF CEMETERY OR CREMATORY Union Chapel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Joppa Harford Md.			
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz				25a. DATE REC'D. BY REGISTRAR JAN 21 1987		25b. REGISTRAR'S SIGNATURE John Anderson			

MEDICAL CERTIFICATION

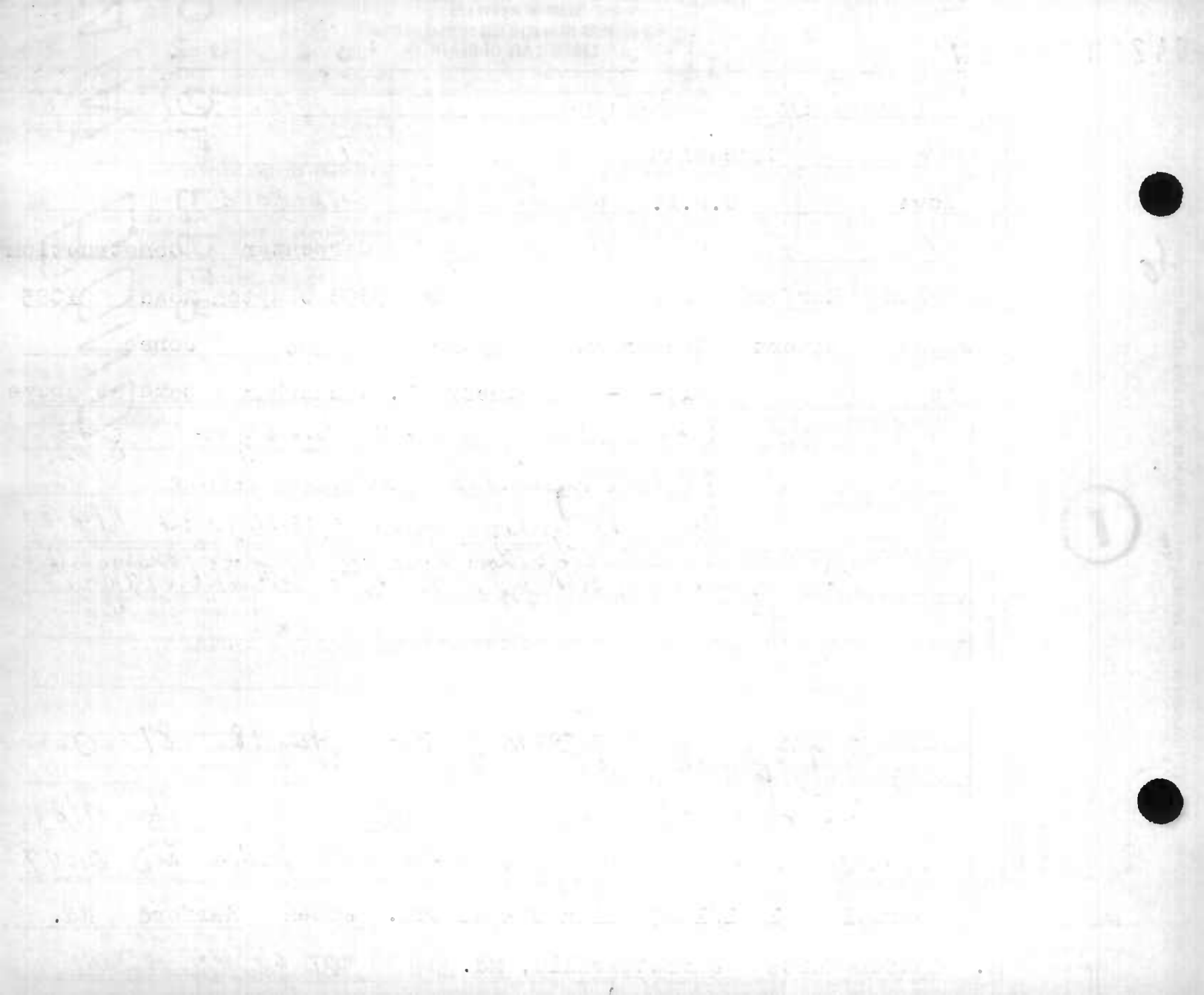
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please stamp the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



040995 JAN 10

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02114  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Edith MIDDLE Leanora LAST Coen <b>Edith L. Coen</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 12 1987</b>		2b. HOUR <b>10:24 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 5, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.	
10. CITY OR TOWN OF DEATH <b>Harre de Grace</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Aberdeen</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>520 Windemere Drive 21001</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Levin Oler Gallion</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Chapman Harward</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>	17. INFORMANT ADDRESS <b>George W. Coen, 3517 McCommas Road, Churchville Md. 21028</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/15 1987</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> , 19 <b>87</b> , to <b>11/12</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11/12</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANTE U. MORAKIL</b>		22c. DATE SIGNED <b>11/12/87</b>		22d. ADDRESS <b>Harre de Grace, Md 21078</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 15, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baker's Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aberdeen Harford Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III, Abingdon, Md. 21009</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1987</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the attending physician be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper which is pasted 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

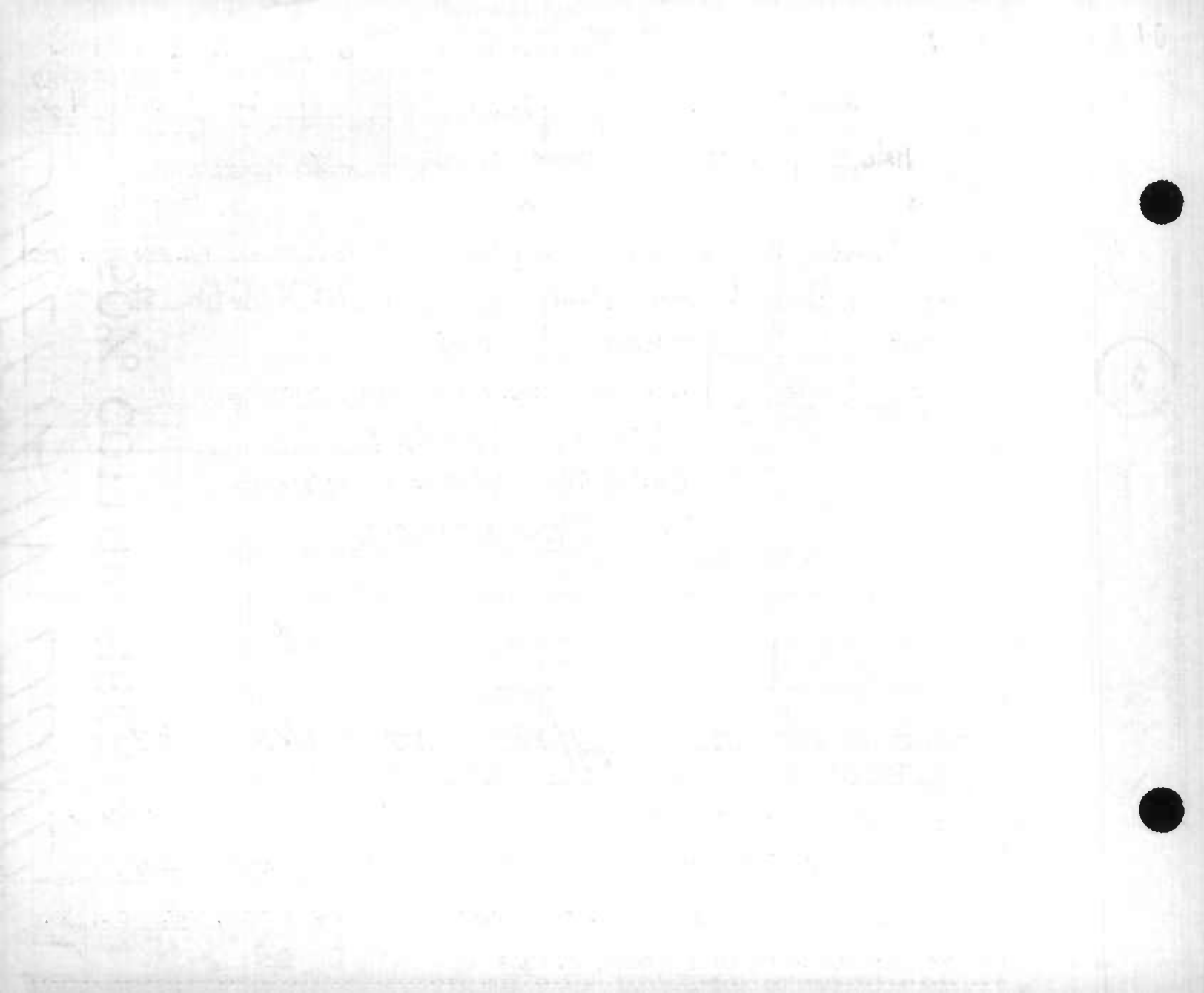
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

042683 FEB 1-3 1987  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Albert E. Czyzewski</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan 30 1987</b>		2b. HOUR <b>4:48 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 31, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>(RET) ELECTRONICS TECH. FED GOVT. (APG)</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD.</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Havre de Grace</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>FELIX CZYZEWSKI</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRANCES DAWGIERT</b>		13e. STREET ADDRESS / ZIP CODE <b>932 Revolution St. 21078</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW II 179 16 7329</b>		17. INFORMANT ADDRESS <b>MRS. JANINE PICKARD 1437 STAFFORD RD DARLINGTON, MD 21034</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:30 1/30 1987</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1/30 1987</b> to <b>1/30 1987</b> , that (I) (we) last saw the deceased alive on <b>1/30 1987</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Dante H. Monakil</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/30/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANTE H. MONAKIL</b>				22e. ADDRESS <b>Havre de Grace, Md., 21078</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2 FEBRUARY 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. ERIN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HAVRE DE GRACE, HARFORD CO., MD.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MD. 21078</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 2 1987</b>		



040276 JAN - 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 02110

1. DECEASED NAME (TYPE OR PRINT) Velma Francis De Haven			2a. DATE OF DEATH MONTH DAY YEAR 1-1-87		2b. HOUR 15 10 PM		
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 25, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN JOPPA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Elmer Vanarsdale		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth		13e. STREET ADDRESS / ZIP CODE 1608 EVA AVE. 21085			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Donald Killinger, 1603 Eva Ave., Joppa, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Lung - Terminal Stage DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-31, 1986, to 1-1, 1987, that (I) (we) lost saw the deceased alive on 1-1, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. J. [Signature]		DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-2-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. J. [Signature]		22e. ADDRESS 433 [Signature] St Harford MD 21088					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/5/87		23c. NAME OF CEMETERY OR CREMATORY Mountain Christian		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford, Maryland	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399		25a. DATE REC'D. BY REGISTRAR JAN 8 1987		25b. REGISTRAR'S SIGNATURE Julia [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



043445 FEB - 1987

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02117  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William Edgar Dolan Jr.			2a. DATE OF DEATH MONTH DAY YEAR (Jan. 16, 1987) 1 16 87			2b. HOUR 1035 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 13, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Fallston (21047)	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Harford Co.	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 804 Old English Court - Apt 2D 21014	
14. FATHER'S NAME FIRST MIDDLE LAST William Edgar Dolan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Edna Sheppard				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-22-0259		17. INFORMANT (Mother) 836-7687 ADDRESS Mrs. F. Edna Dolan 804 Old English Court - Apt 2D Bel Air, Maryland 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemodynamic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Vascular hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Anoxic Encephalopathy							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George LAUS MD.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George LAUS MD.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 19, 1987		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Meth. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Emmorton Harford Co. Maryland	
24. FUNERAL DIRECTOR Joseph William Foster Superior Funeral				50 W. Broadway & Williams St. Bel Air, Maryland 21014		25a. DATE REC'D BY REGISTRAR FEB 02 1987	
				25b. REGISTRAR'S SIGNATURE Julia Anderson-Pandora			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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042681 FEB 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02118

1. DECEASED NAME (TYPE OR PRINT) <b>Edward Aloysius Dougherty</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>1/23/87</b>			2b. DATE OF DEATH MONTH DAY YEAR <b>1 23 1987</b>			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 23 1987</b>		
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 29 23</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>63 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN <b>0 0</b>	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORFOLK</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORFOLK</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b>		
10. CITY OR TOWN OF DEATH <b>Aberdeen</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b></b>			12b. KIND OF BUSINESS OR INDUSTRY <b></b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>HARFORD</b>			13c. CITY OR TOWN <b>Aberdeen</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward A Dougherty Sr</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Geraldine Roscoe</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>222-12 7145</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>222-12 7145</b>			17. INFORMANT ADDRESS <b>Personal paper</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Ca of Lungs.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b></b>											
19a. DATE OF OPERATION <b></b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b></b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b></b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Luis E. Renjel</b>			TITLE (SPECIFY) <b>Deputy</b>			MEDICAL EXAMINER <b></b>			DATE SIGNED <b>1-23-87</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Luis E. Renjel MD</b>			ADDRESS <b>464 Alliance St</b>			<b>Havre</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>24 JAN. 1987</b>			23c. NAME OF CEMETERY OR CREMATORY <b>R.A. Ferris &amp; Co</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>WEST CHESTER CHESTER PENNA</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>TARRING FUNERAL HOME, P.A., ABERDEEN, MD. 21001-3399</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1987</b>			25b. REGISTRAR'S SIGNATURE <b></b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN AUTOPSY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. A COPY WITH FORM PM 3, BETA IN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND											
DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
REG. NO. 87 02119											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNICE BURKE DOWLING					2a. DATE OF DEATH MONTH DAY YEAR January 29, 1987			2b. HOUR 8:45P <sup>M</sup>			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 31, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 614 Cedar Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY OR TOWN Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John --- Burke					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie --- Gordon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Bel Air, Md. 21014 Clifton M. Dowling, Jr., 614 Cedar Lane							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) hypertensive arteriosclerotic cardiovasc. dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes mellitus, non-insulin dependent											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from January 19, 1978 to January 29, 1987, that (I) (we) lost saw the deceased alive on November 6, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ben Oteyza					DEGREE M. D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 1-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ben Oteyza, M.D.					22e. ADDRESS 846 S. Main St., Bel Air, Md. 21014						
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial			23b. DATE Feb. 1, 1987		23c. NAME OF CEMETERY OR CREMATORY Franklinville Presbyt. Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 2 1987 Julia Swanson-Randall						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE-MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please return carbon duplicate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, the medical examiner must be notified at once.

The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The second part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The third part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The fourth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The fifth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The sixth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The seventh part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The eighth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The ninth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The tenth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all non-papers pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes Catherine Drexel					2a. DATE OF DEATH MONTH DAY YEAR Jan. 23, 1987			2b. HOUR 10:00Am	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 3 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 805 Dellwood Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 805 Dellwood Drive 21047	
14. FATHER'S NAME FIRST MIDDLE LAST George Reed					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Finn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-20-4558		17. INFORMANT ADDRESS John C. Drexel (son) same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a None									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 86 to 19 86, that (I) (we) last saw the deceased alive on 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE The					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. N. AIR					22e. ADDRESS 2112 Belair Road. Balto.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/27/87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 9705 Belair Rd., Balto. Md. 21236						25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE Julia T. ...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If the death certificate is not filled in by the funeral director, page 3 should be filled in by the funeral director. If the death certificate is not filled in by the funeral director, page 3 should be filled in by the funeral director.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the death certificate must be signed by a physician.

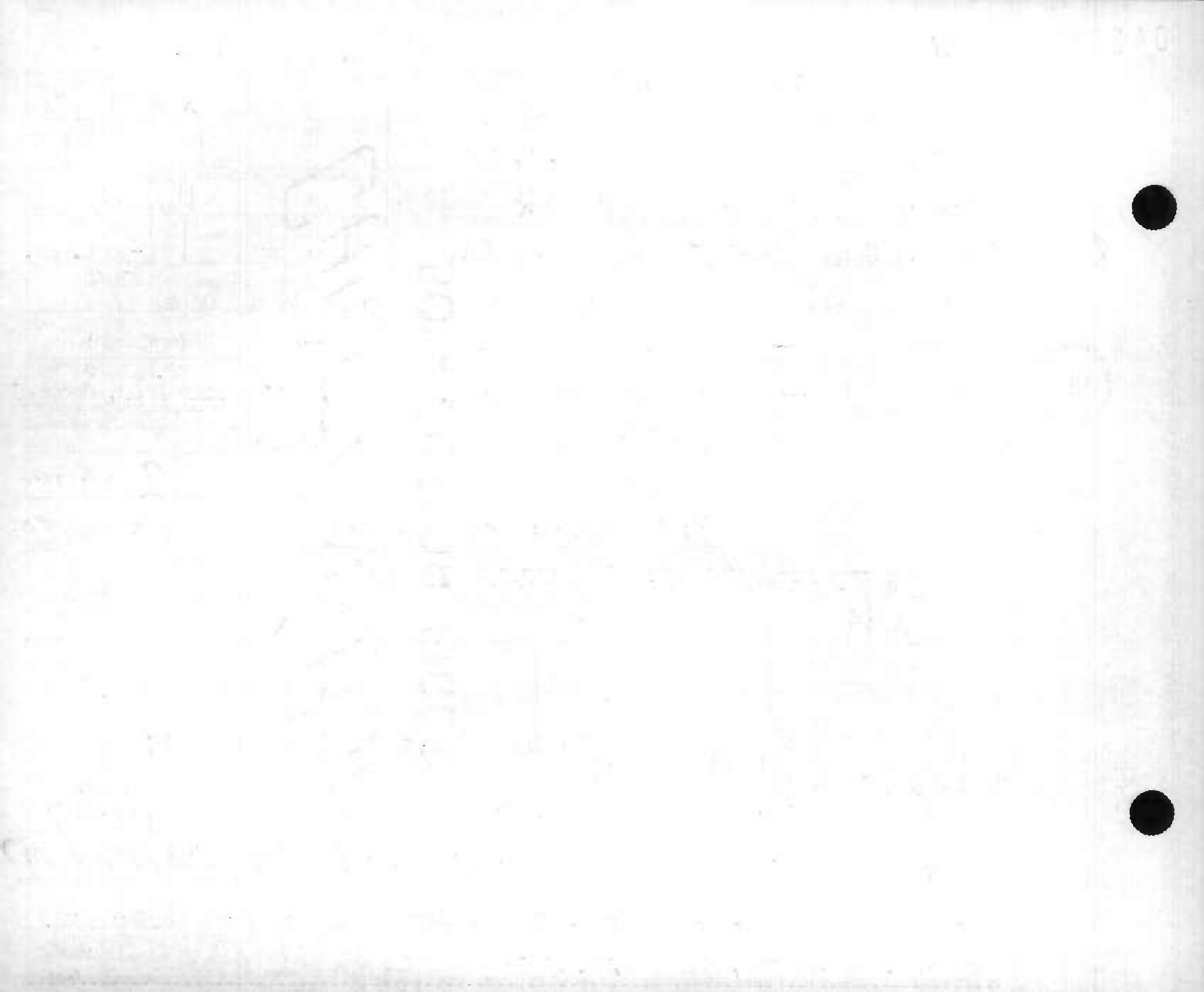
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FOR  
STATE  
REGISTRAR
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

8702121

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Clara</u> MIDDLE <u>Kimble</u> LAST <u>Ducey</u> <u>Clara K. Ducey</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>Jan 29, 1987</u>		2b. HOUR <u>7:45 A.M.</u>
3. SEX <u>Female</u>	4. RACE <u>white</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>Nov. 7, 1908</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford</u> MD.	
10. CITY OR TOWN OF DEATH <u>Havre de Grace</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Harford Memorial Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Inspector</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>US-govt. Ret.</u>
13a. STATE <u>Md.</u>		13b. COUNTY <u>Harford</u>	13c. CITY OR TOWN <u>Edgewood</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>George</u> <u>---</u> <u>Kimble</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Erma</u> <u>---</u> <u>(unknown)</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>220-20-7574</u>		17. INFORMANT ADDRESS <u>Md. 21040</u> <u>Clara E. Kobylecki, 2021 Hanson Road, Edgewood</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPALMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MALNUTRITION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF LUNG</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u> <u>13 MONTHS</u>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>CARCINOMA OF LUNG &amp; PROSTATE</u>					
19a. DATE OF OPERATION <u>NA</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NA</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-23</u> , 19 <u>87</u> , to <u>1-29</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1-29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Charles R. Eck MD</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>1/29/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHARLES R. ECK JR MD</u>		22e. ADDRESS <u>223 W. BELAIR AVE, ABERDEEN, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Jan. 31, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Havre de Grace Harford Md.</u>		24. FUNERAL DIRECTOR NAME ADDRESS <u>Howard K. McComas III, Abingdon, Md. 21009</u>			
25a. DATE RECD. BY REGISTRAR <u>FEB 23 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 02122

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Royal William Eberius			2a. DATE OF DEATH MONTH DAY YEAR 1 10 87			2b. HOUR P <sup>M</sup> 4:10	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 16 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2509 Reckord Rd. Fallston				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Letter Carrier	
12b. KIND OF BUSINESS OR INDUSTRY U.S. Postal Ser.							
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Fallston		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2509 Reckord Rd. Fallston, Md. 21047				
14. FATHER'S NAME FIRST MIDDLE LAST William G. Eberius				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Seipe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-44-9744		17. INFORMANT ADDRESS Lois K. Schultz 2509 Reckord Rd. Fallston, Md. 21047			
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>BLADDER CARCINOMA</u> ~10 mos DUE TO, OR AS A CONSEQUENCE OF: (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT SCHOOL <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Nov 19 86 1/10 87			
22a. I certify that (1) this hospital attended the deceased from 1/15/87 to 1/10/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body of the deceased.							
22b. SIGNATURE <i>Joan Edwards</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joan Edwards M.D. (877-3393)				22e. ADDRESS 2112 Belair Rd. Suite 10 Fallston, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-14-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Lassphat Funeral Home				25a. DATE REC'D. BY REGISTRAR JAN 13 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Dandrea</i>	

RECEIVED

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02123

1. DECEASED NAME (TYPE OR PRINT) <b>PHILIP L. ENDLICH, JR.</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 3 19 87			2b. HOUR M 6:45 AM		
3. SEX <b>Male</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10/23/69</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>17 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 4 19 87</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Joppa</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>farm-2008 Old Joppa Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>
13a. STATE <b>Md.</b>			13b. CITY <b>Harford</b>		13c. CITY OR TOWN <b>Joppa</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Philip L. Endlich, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Diane Braskis Md. 21085</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216-66-4154</b>		17. INFORMANT ADDRESS <b>Philip L. Endlich, Sr. same add.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Contact gunshot wound of head (unspecified weapon)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR P.M. <b>1-3- 1987</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self-inflicted.</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>farm</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2008 Old Joppa Rd., Joppa, Harford MD</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Charles P. Kokes</i>			TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER			DATE SIGNED <b>1-4-87</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Charles P. Kokes, M.D.</b>			ADDRESS <b>111 Penn St., Balto., MD 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/7/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>9705 Belair Road, Balto., Md. 21236</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 9 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rudolph</i>	

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. These please remove carbon page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

141305 Jan 20 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02124  
REG. NO

1. DECEASED NAME (TYPE OR PRINT) <b>CHRISTINE B ENSLEY</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>13</b> YEAR <b>87</b>		2b. HOUR <b>1239</b> <sup>AM</sup>
3. SEX <b>F</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>31</b> YEAR <b>18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.	
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GENERAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>1311 MD</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>JO PPA</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>612 Sugarhill Rd 21085</b>	
14. FATHER'S NAME FIRST <b>Richard</b> MIDDLE <b></b> LAST <b>Blount</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Jennie</b> MIDDLE <b></b> LAST <b>Spratley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>UNK</b>	17. INFORMANT ADDRESS <b>Livingston Ensley 612 Sugar Hill Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>END STAGE RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Andrew Nowakowski MD</b>		DEGREE <b>MD</b>		22f. DATE SIGNED <b>1/13/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREW NOWAKOWSKI MD</b>		22e. ADDRESS <b>125 N. MAIN ST BELAIR, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (ECRY) <b>Burial</b>	23b. DATE <b>1/17/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Surry</b> COUNTY <b></b> STATE <b>Va.</b>	
24. FUNERAL DIRECTOR NAME <b>MARCH F/H 1101 E. North Avenue</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1987</b>		
			25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please send your completed page 3 to the funeral director. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 02125	
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM CLINTON EDWARDS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1-14-87</b>		2b. HOUR <b>1:30 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 9, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY, MD.</b>					
10. CITY OR TOWN OF DEATH <b>HAVRE DE GRACE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HARFORD MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>(RET) PLUMBER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FED. GOVT.</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>HAVRE de GRACE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>502 CONGRESS AVE. APT 210 21078</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>RICHARD EDWARDS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH DEBAUGH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>219 10 4936</b>		17. INFORMANT ADDRESS <b>MRS. HELEN CULLUM, SAME AS #13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>multi-focal encephalopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic salivary</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1/11/87</b> to <b>1/14/87</b> , that (I) (we) last saw the deceased alive on <b>1/14/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>SILVERSTEIN</b>				DEGREE <b>PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>14 JANUARY 87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SILVERSTEIN</b>				22e. ADDRESS <b>P.O. Box 8 HdG, MD 21078</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>17 JANUARY 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK RUN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCK RUN, HARFORD COUNTY, MARYLAND</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John F. ...</b>			

11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300

301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400

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601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700

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1401 1402 1403 1404 1405 1406 1407 1408 1409 1410 1411 1412 1413 1414 1415 1416 1417 1418 1419 1420 1421 1422 1423 1424 1425 1426 1427 1428 1429 1430 1431 1432 1433 1434 1435 1436 1437 1438 1439 1440 1441 1442 1443 1444 1445 1446 1447 1448 1449 1450 1451 1452 1453 1454 1455 1456 1457 1458 1459 1460 1461 1462 1463 1464 1465 1466 1467 1468 1469 1470 1471 1472 1473 1474 1475 1476 1477 1478 1479 1480 1481 1482 1483 1484 1485 1486 1487 1488 1489 1490 1491 1492 1493 1494 1495 1496 1497 1498 1499 1500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) WALTER E. FULLER					2a. DATE OF DEATH MONTH DAY YEAR 1 28 87			2b. HOUR 5:00A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 17, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		8b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.			
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY STEEL INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY HARFORD 13c. CITY OR TOWN HAVRE de GRACE					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3647 OLD LEVEL ROAD 21078		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM C. FULLER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA SHOOK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 194 01 4827		17. INFORMANT ADDRESS MRS. LEONA NEWMAN SAME AS #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Progressive Myotonic Dystrophy</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Leticia S. Alvarez</i>					DEGREE M.D.			22c. DATE SIGNED 1-28-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LETICIA S. ALVAREZ, M.D.					22e. ADDRESS 625 S. UNION AVE. HAVRE DE GRACE, MD. 21078				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 31 JANUARY 87		23c. NAME OF CEMETERY OR CREMATORY EMANUEL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE LEWISBERRY, YORK COUNTY, PA.			
24. FUNERAL DIRECTOR COCKLIN FUNERAL HOME, DILLSBURG, PA. NAME ADDRESS					25a. DATE RECORDED BY REGISTRAR JAN 30 1987				

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 02121

1. DECEASED NAME (TYPE OR PRINT) <b>John E Edward Godfrey, Sr.</b>			7a. DATE OF DEATH MONTH DAY YEAR <b>1 13 87</b>			7b. HOUR <b>2<sup>30</sup> a</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 3 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.			
10. CITY OR TOWN OF DEATH <b>Fallston</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Warehouse Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Storage</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Bel Air</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sebastian E. Godfrey</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose -- Peterson</b>			13e. STREET ADDRESS / ZIP CODE <b>714 Country Village Drive 21014</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No --</b>			16b. SOCIAL SECURITY NO. <b>144-10-1457</b>		17. INFORMANT ADDRESS <b>Marion S. Godfrey, 714 Country Village Drive Bel Air, Md. 21014</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Disseminated Intravascular Coagulation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lung Carcinoma</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>6 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Long Smoking History</b>					
19a. DATE OF OPERATION <b>1/13</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>1/13</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/13</b> , 19 <b>87</b> , to <b>1/13</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>1/13</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>David McClure MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/13/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID McCLURE MD</b>		22e. ADDRESS <b>1131 Bel Air Road Bel Air Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 16, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Graceland Memorial Park, Kenilworth Union N.J.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air Md.</b>		24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III, Abingdon, Md. 21009</b>			
25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Anderson-Pendall</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial or cremation. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

02128

1. DECEASED NAME (TYPE OR PRINT) Stella Maud Grafton			2a. DATE OF DEATH MONTH DAY YEAR Jan. 2, 1987			2b. HOUR 10 45 a.m.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1903		6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Joppa		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2400 Old Mountain Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY HARFORD		13c. CITY OR TOWN JOPPA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST UNK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. NA			17. INFORMANT ADDRESS Wanda Cullum, 2400 Old Mountain Rd, Joppa, Md. 21085				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a) Recurrent STROKE		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/2, 1987, to 1/2, 1987, that (I) (we) last saw the deceased alive on 1/2, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE Dante Monakil MD				DEGREE MD		22c. DATE SIGNED 1/2/87		22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL				23b. ADDRESS Harre de Grace Md 21088					
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/CREMATION		23d. DATE JAN. 3, 1987		23e. NAME OF CEMETERY OR CREMATORY R.A. FERRIS & Co.		23f. LOCATION CITY OR TOWN COUNTY STATE W. CHESTER, CHESTER, PENNA.			
24. FUNERAL DIRECTOR NAME TARPEN FUNERAL HOME, P.A., ABERDEEN MD. 21001-3399				25a. DATE REC'D. BY REGISTRAR JAN 8 1987		25b. REGISTRAR'S SIGNATURE Julia Benson-Richard			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page is to be given to the funeral director to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any information of a traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 DECEASED NAME (TYPE OR PRINT) <b>OLIVIA C. GRANT</b>					2a DATE OF DEATH MONTH <b>1</b> DAY <b>8</b> YEAR <b>1987</b>		7b HOUR <b>11:30 P<sub>M</sub></b>			
3. SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>25</b> YEAR <b>1894</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>YSA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY MD.</b>				
10 CITY OR TOWN OF DEATH <b>HAVRE DE GRACE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CITIZENS NURSING HOME</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Clerk</b>		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>Md/</b>					13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b></b> LAST <b>Stehli</b>					15 MOTHER'S MAIDEN NAME FIRST <b>Florence</b> MIDDLE <b>V.</b> LAST <b>Smith</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. <b>213-14-2938</b>		17 INFORMANT ADDRESS <b>Winter Park, Fla 32789</b> <b>Mr. Frank L. Strhli 10 Howell Branch Rd.</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced generalized arterio-sclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Degenerative ulcers</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input checked="" type="checkbox"/> AT HOME AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22 I certify that (I, (the hospital) attended the deceased from <b>5-6</b> 19 <b>87</b> to <b>1-8</b> 19 <b>87</b> that (I, (we) last saw the deceased alive on <b>4-6</b> 19 <b>87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I, (we) did) (did not) view the body after death.										
22b SIGNATURE <b>[Signature]</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				DATE SIGNED <b>1/9/88</b>		
22c PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ANNA KAWA M.D.</b>				22d ADDRESS <b>318 S. Union Ave. Hdg. Md. 21078</b>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b DATE <b>Jan. 10, 1987</b>		23c NAME OF CEMETERY OR CREMATORY <b>Westview Memorial</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto. MD.</b>				
24 FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>				25a DATE REC'D. BY REGISTRAR <b>JAN 12 1987</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>				

BP

1000 N. Delaware Avenue, Suite 1000  
Wilmington, Delaware 19801  
Tel: 313-421-1111  
Fax: 313-421-1112  
www.1000na.com

1000 N. Delaware Avenue, Suite 1000  
Wilmington, Delaware 19801  
Tel: 313-421-1111  
Fax: 313-421-1112  
www.1000na.com

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 02130  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DENISE EILEEN GRIMM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 12 87</b>			2b. HOUR MIN. <b>10:35 PM</b>					
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 17 50</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>36</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>Fallston</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston Gen. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Data Processor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Harford</b>		13c. CITY OR TOWN <b>Bel Air</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2100 N. Ridge Drive 21014</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Francis Samuel Grimm</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Florence Cole</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>219-60-8550</b>	
17. INFORMANT ADDRESS <b>Md. 21050</b>			17. INFORMANT ADDRESS <b>Donald K. Grimm, 2434 Gibson Road, Forest Hill</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHIAL CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>20 non</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/12/87</b> to <b>1/12/87</b> , that (I) (we) lost saw the deceased alive on <b>1/12/87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>John P. Edwards</b>			22c. ADDRESS <b>212 BEL AIR RD, FALLSTON, MD</b>			22d. DATE SIGNED <b>1/13/87</b>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			22g. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 15, 1987</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Churchville Presbyterian Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Churchville-Harford-Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III, Abingdon, Md. 21009</b>						25a. DATE REC'D BY REGISTRAR <b>JAN 16 1987</b>					
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>											





041853 JAN 28

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02131

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		xx MONTH DAY YEAR		2b. HOUR	
Donald		Andrew		Gullion				1/19		19		87	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
M	W	8 MONTH DAY YEAR		43 YRS.		MONTHS DAYS HOURS MIN.				1/19		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
VA		USA				Harford							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Fallston		Fallston General Hospital		Laborer		Const.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD		Harford		Edgewood		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		959 Topview Dr.		21040			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Conley		Trigg		Flora		M.		Hall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		N/A		217-40-9026		Wife		same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) CORONARY HEART DISEASE													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b) ASCVD													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Luis E. Renjel				M.D. Deputy				MEDICAL EXAMINER				1/20/87	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Luis E. Renjel MD				464 Alliance St. Havre De Grace, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				1-22-87		Bel Air Mem. Gdns.				Bel Air, Harford, Maryland			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Tarrington Funeral Home, PA, Aberdeen, MD, 21001-3399				JAN 27 1987				Julia Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM-3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

DND

9381



ALBERTA

041852 JAN 20 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 0 2 1 3 2  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) William Gordon Hannaway W. Gordon Hannaway			2a DATE OF DEATH MONTH DAY YEAR 1-20-87		2b HOUR 10:45 AM
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR July 3, 1911	6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.		
10 CITY OR TOWN OF DEATH Bel Air	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b KIND OF BUSINESS OR INDUSTRY Religion
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE Maryland	13b COUNTY Harford	13c CITY OR TOWN Abingdon	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 2924 Carlyle Court 21009	
14 FATHER'S NAME FIRST MIDDLE LAST Harry James Hannaway		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rae Faunce Duffy			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 207-07-3634		17 INFORMANT ADDRESS: Abingdon, Md. 21009 Mrs. Elizabeth H. Hannaway, 2924 Carlyle Ct.	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>aspiration (vomit)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>arterio-sclerotic cardiovascular disease</u>					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>12/16/83</u> 19 <u>83</u> to <u>1/20</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>BEN O'FEY/ZA</u>		DEGREE MD	22c DATE SIGNED 1/20/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) BEN O'FEY/ZA		22e ADDRESS 846 S. MAIN ST. Bel Air, Md. 2101x			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Jan. 24, 1987	23c NAME OF CEMETERY OR CREMATORY Riverside Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Norristown Montgomery Pa		
24 FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009		25a DATE REC'D. BY REGISTRAR JAN 27 1987	25b REGISTRAR'S SIGNATURE Julia Swain		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be maintained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 02133 REG. NO.			
1. FOR STATE REGISTRAR													
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HAROLD WARDER HEFNER										7a. DATE OF DEATH MONTH DAY YEAR 1 19 87		7b. HOUR 530 P.M.	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR May 26, 1903			6. AGE (IN YEARS LAST BIRTHDAY) MONTH DAY YEAR 83 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.				
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist			12b. KIND OF BUSINESS OR INDUSTRY Railroad				
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Joppa			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 103 Arbutus Drive 21085	
14. FATHER'S NAME FIRST MIDDLE LAST Howard --- Hefner						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora --- Warder							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none			17. INFORMANT ADDRESS Md. 21085 Margaret E. Harvey, 103 Arbutus Drive, Joppa							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severely dehydrated state/pain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic carcinoma of prostate</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 <sup>30</sup> PM 1/19/87 Several weeks Since 4/86			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pathological fracture of ribs</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Jan. 18, 87 to Jan. 19, 87, that (I) (we) lost above, (I) (we) (did) (did not) see the body after death, and that in my (our) opinion death occurred on the date and hour and from the causes stated													
22b. SIGNATURE Albert S. C. Sun, M.D.						DEGREE			22c. DATE SIGNED Jan. 20, 87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S. C. Sun, M.D.						22e. ADDRESS 1800 Harford Rd. Fallston, MD 21047							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Jan. 22, 1987			23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE W. Chester Chester Pa.				
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009						25a. DATE RECEIVED BY REGISTRAR JAN 27 1987							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial transit permit. Then please reattach pages 1 and 2 to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 chosen, any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02134  
REG. NO

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST ANTOINETTE M. HILL		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1987		2b. HOUR 25 AM	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 29, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY, MD.			
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3237 CANTERBURY LANE 21047				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND		13b. CITY OR TOWN HARFORD		13c. CITY OR TOWN FALLSTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3237 CANTERBURY LANE 21047	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE AUGUSTINIAK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS 216-05-1062 VIOLET H. WHITE FALLSTON, MD 21047					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>general debilitation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>age</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/11/86</u> 19 <u>86</u> to <u>12/22</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>12/22</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
27b. SIGNATURE <u>Robert L. Smith</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				27c. DATE SIGNED <u>1/7/87</u>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. SMITH, MD.				27e. ADDRESS 2303 Belair Road 879-3666					
28a. BURIAL, CREMATION, REMOVAL (CHECK ONE) BURIAL		28b. DATE JAN. 9, '87		28c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		28d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND			
29a. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON				ADDRESS 8521 LOCH RAVEN BLVD.		29b. DATE REC'D. BY REGISTRAR JAN 7 1987		29c. REGISTRAR'S SIGNATURE <u>John William Johnson</u>	

BP



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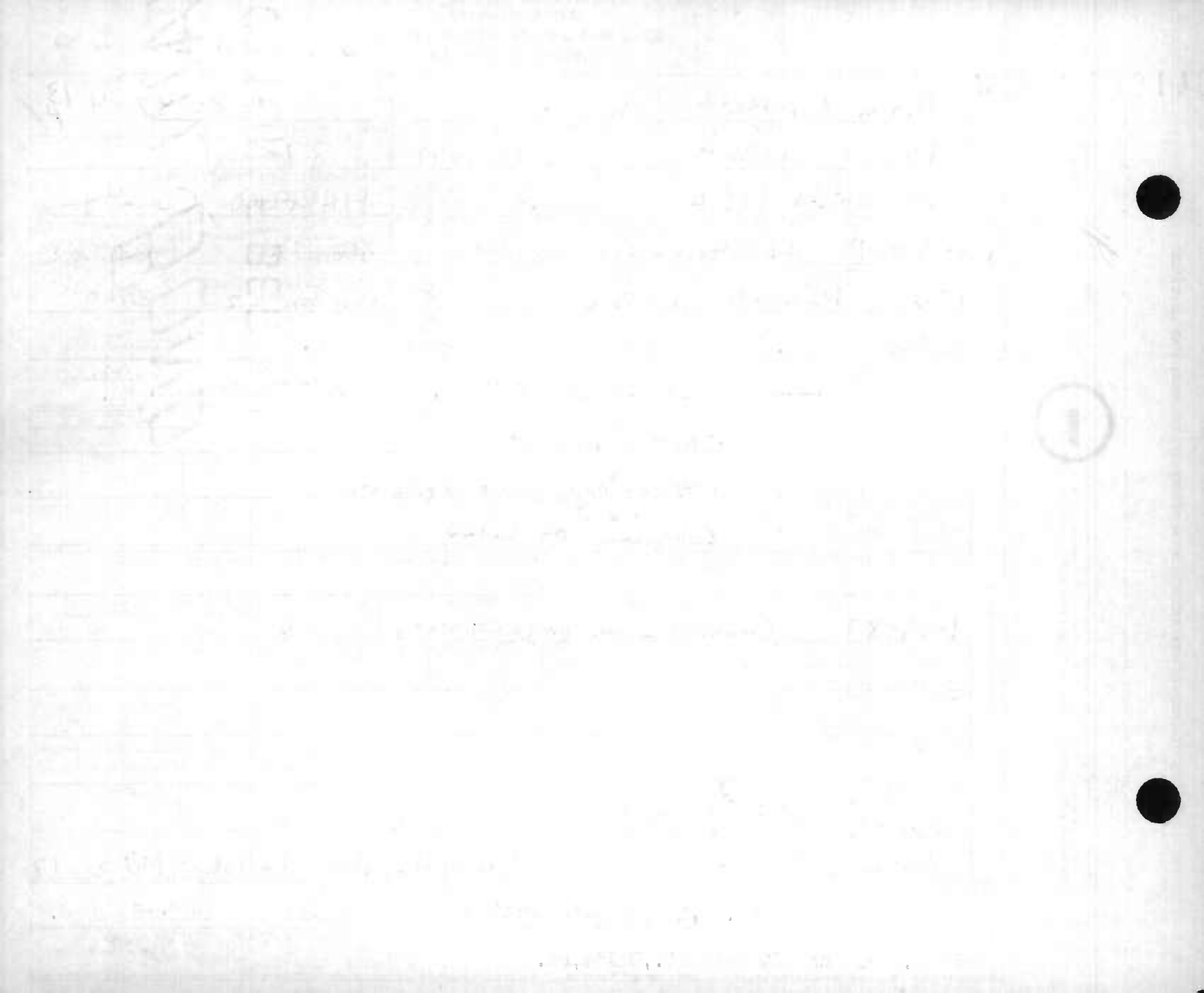
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 02135 REG. NO.					
1. DECEASED NAME TYPE OR PRINT William Emmett Horton										2a. DATE OF DEATH MONTH DAY YEAR 1-20-87		2b. HOUR 443 p.m.			
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 07-17-1899			6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD County MD.						
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Automotive			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE MD			13b. COUNTY HARFORD			13c. CITY OR TOWN Whiteford			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rd. Box 162 21160			
14. FATHER'S NAME FIRST MIDDLE LAST William E. Horton					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence J. Russell										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					16b. SOCIAL SECURITY NO. 219-01-7768					17. INFORMANT ADDRESS Billy M. Horton 2065 GlenCove Rd. Md. Darlington					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>  DUE TO, OR AS A CONSEQUENCE OF (b) <u>MASSIVE MYOCARDIAL INFARCTION</u>  DUE TO, OR AS A CONSEQUENCE OF (c) <u>GANGRENE OF COLON</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.															
19a. DATE OF OPERATION 1-19-87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Emergency Colectomy & Colostomy						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (each) did not view the body after death.															
22b. SIGNATURE DEGREE Attending Physician										22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OF PRINT) William Amoss										22e. ADDRESS 200 M. Hwy Ave. Fallston, MD 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 23, 1987			23c. NAME OF CEMETERY OR CREMATORY Dublin Southern			23d. LOCATION CITY OR TOWN COUNTY STATE Dublin Harford Md.						
24. FUNERAL DIRECTOR NAME John H. Harkins 600 Main St., Delta, Pa.										25a. DATE REC'D. BY REGISTRAR JAN 27 1987		25b. REGISTRAR'S SIGNATURE			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02130

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RUTH BEATRICE JAYNES		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Jan. 27 1987		7b. HOUR 12:58 A M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Oct. 12, 1896	6. AGE (IN YEARS) LAST BIRTHDAY 90 YRS.	7c. DATE PRONOUNCED DEAD January 27, 1987
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		MD.		
10. CITY OR TOWN OF DEATH Street		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3326 Forge Hill Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher
12b. KIND OF BUSINESS OR INDUSTRY School				
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Street	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET ADDRESS 3326 Forge Hill Road		21154		
14. FATHER'S NAME FIRST MIDDLE LAST Alexander -- Hamilton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgie -- Hamilton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 169-34-5260-A		17. INFORMANT ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>A. S. C. V. D.</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Luis E. Renjel TITLE (SPECIFY) Deputy MEDICAL EXAMINER  
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D. ADDRESS 464 Alliance St., Havre de Grace, Md. 21078  
DATE 1-27-87  
SIGNED 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Jan. 28, 1987	23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE W. Chester Chester Pa.
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D BY REGISTRAR JAN 29 1987	25. REGISTRAR'S SIGNATURE <u>Giles Anderson</u>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

1934

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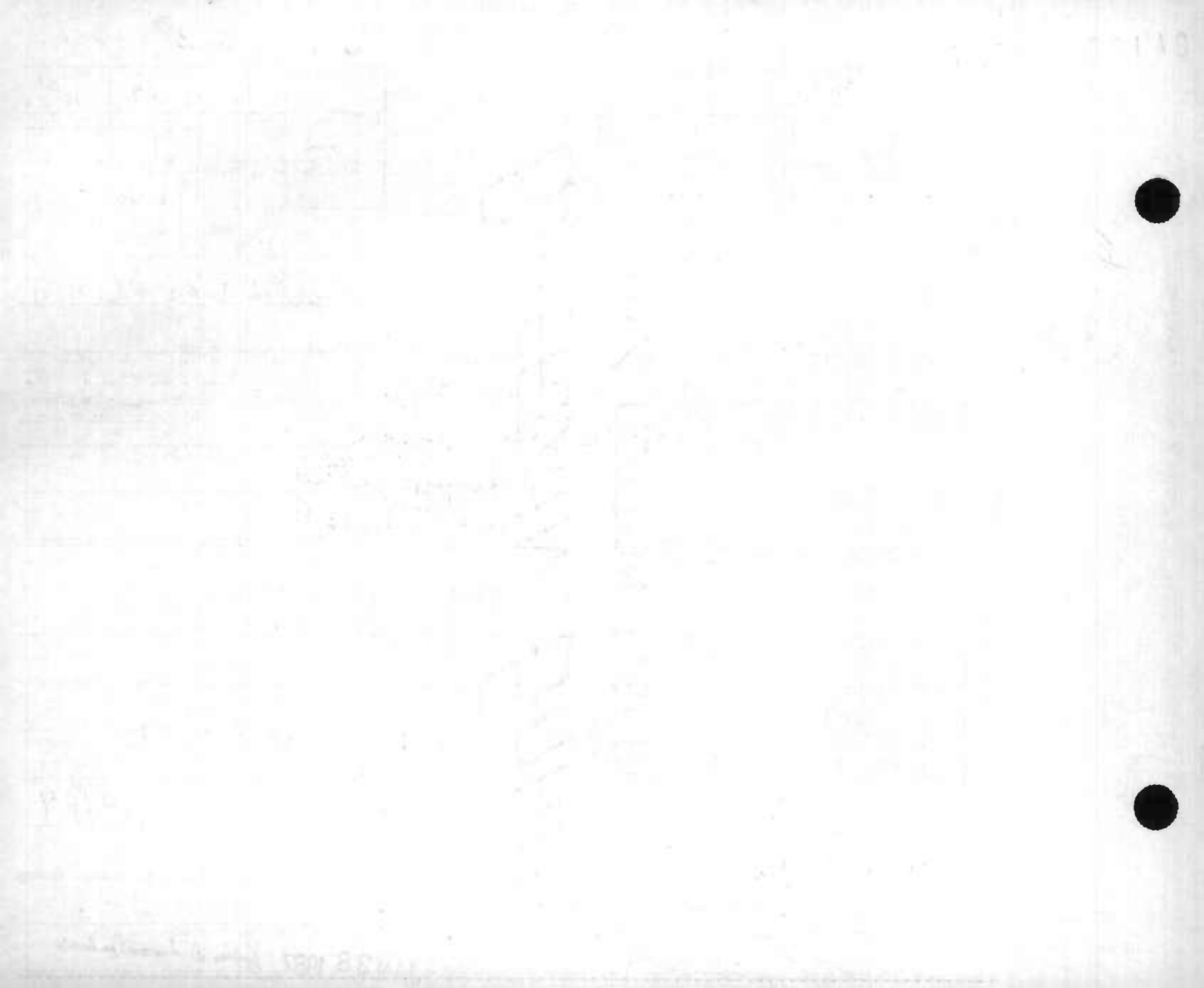
1934

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Opal</u> MIDDLE: <u>R.</u> LAST: <u>Jennings</u>			2a. DATE OF DEATH MONTH: <u>1</u> DAY: <u>18</u> YEAR: <u>87</u>			2b. HOUR <u>10<sup>51</sup></u> P.M.					
3. SEX <u>Female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH: <u>July</u> DAY: <u>20</u> YEAR: <u>1914</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS.		7. IF UNDER 1 YEAR MONTHS: <u></u> DAYS: <u></u>		7. IF UNDER 72 HRS HOURS: <u></u> MIN: <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>W. Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford</u> MD.					
10. CITY OR TOWN OF DEATH <u>Norve de Grace</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Harford Memorial Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		
13a. STATE <u>Md.</u>		13b. COUNTY <u>Cecil</u>		13c. CITY OR TOWN <u>Rising Sun</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>2516 Red Toad Rd. 21911</u>			
14. FATHER'S NAME FIRST: <u>Wardon E.</u> MIDDLE: <u>Waugh</u> LAST: <u></u>				15. MOTHER'S MAIDEN NAME FIRST: <u>Nellie</u> MIDDLE: <u>Dixon</u> LAST: <u></u>				16. ADDRESS <u>2516 Red Toad Rd. Rising Sun, Md. 21911</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>128-18-6225</u>		17. INFORMANT <u>Kenneth B. Jennings</u>							
18. CAUSE OF DEATH (Enter only one cause per part I. Death was caused by: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-12</u> , 19 <u>87</u> , to <u>1-18</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1-18</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Brian T. Yeo, M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>1/19/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Brian T. Yeo, M.D.</u>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>1-23-87</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Lenawee Hills Cem.</u>			23d. LOCATION CITY OR TOWN: <u>Adrian</u> COUNTY: <u>Lenawee</u> STATE: <u>Mich.</u>		
24. FUNERAL HOME <u>Funeral Home North East, Md.</u>						25a. DATE REC'D. BY REGISTRAR <u>JAN 28 1987</u>			25b. REGISTRAR'S SIGNATURE <u>Julia S. [Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 02138	
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) Marie Magness Johnson				2b. DATE OF DEATH MONTH DAY YEAR 01 26 87				2c. HOUR 11 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 17 14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. CITY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 403 Vale Road 21014			
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Magness				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara E. Pennington							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-34-706		17. INFORMANT Marvin L. Johnson, 403 Vale Road, Bel Air, Md.		ADDRESS 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disseminated CA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jas. Reinhardt for Dr. Vossler				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1-26-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 29, 1987		23c. NAME OF CEMETERY OR CREMATORY Mountain Christian Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Joppa Harford Md.					
24. FUNERAL DIRECTOR NAME Howare K. McComas III, Abingdon, Md. 21009						25a. DATE REC'D. BY REGISTRAR JAN 29 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson			

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please deliver this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted for an autopsy.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR <b>Dorothy Catherine Joswick</b>		REG. NO. <b>87 02139</b>							
1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy C. Joswick</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1-29-87</b>							
3. SEX <b>Female</b>		4. RACE <b>White</b>							
5. DATE OF BIRTH MONTH DAY YEAR <b>November 10, 1935</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.							
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial</b>							
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>							
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md. Harford</b>		13b. CITY OR TOWN <b>Aberdeen</b>							
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>William Deford</b>		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Dorothy Dietz</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, LAST OR UNKNOWN) (IF " " GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-34-7203</b>							
17. INFORMANT ADDRESS <b>Dorothy Bobiett 1615 Rickenbacker Rd. 21221</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro-vascular thromboses</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive cerebro-vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes Mellitus</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>							
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK							
21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____ that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Irvin L. Wachsmann</b>		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IRVIN L. Wachsmann</b>		22e. ADDRESS <b>407 S Union Ave. Havre de Grace, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>1/31/87</b>							
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Md.</b>							
24. FUNERAL DIRECTOR <b>Bruzdinski Funeral Home PA 1407 Old Eastern Ave.</b>		25a. DATE RECD. BY REGISTRAR <b>FEB 2 1987</b>							

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UNITED STATES DEPARTMENT OF AGRICULTURE

No. 2212

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

040473 JAN 12

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 02140

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT</b> <b>Francis</b> <b>KAHOE</b>			2a. DATE OF DEATH (January 3) <b>1-3-87</b>		2b. HOUR <b>12:15</b> P M
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>12</b> YEAR <b>24</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Fallston (21047)</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HEATING OIL Sales</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford Co.</b>	13c. CITY OR TOWN <b>Bel Air</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Stephen</b> MIDDLE <b>Michael</b> LAST <b>KAHOE</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Vivian</b> MIDDLE <b>Colgan</b> LAST <b>Colgan</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES - Navy</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW2</b>	17. INFORMANT (Sow) <b>838-5210</b> ADDRESS <b>9 South Hickory Avenue</b> <b>Mr. Robert F. Kahoe, Jr. Bel Air, Maryland 21014</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation . Asystole (Cardiac arrest)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Amiable MI. (Sudden death)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>Cirrhosis of liver, Portal Hypertension . -yo.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1-1-87</b> to <b>1-3-87</b> , that (I) (we) lost saw the deceased alive on <b>1-1-87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>B.D. PAREKH</b>		DEGREE <b>MD.</b>		22c. DATE SIGNED <b>12/3/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B.D. PAREKH M.D.</b>		22e. ADDRESS <b>1908 HARFORD RD, FALLSTON, MD. 21047</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Jan 6, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Ignatius Cath. Ch. Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Forest Hill, Harford Co, Maryland 21050</b>		
24. FUNERAL DIRECTOR <b>Joseph William Foster</b> <b>Funeral Home</b>		50 W. Broadway & Williams St ADDRESS <b>Bel Air, Maryland 21014</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 7 1987</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "the" are visible.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the body permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE A LAST Keller			2a. DATE OF DEATH MONTH DAY YEAR Jan. 11 1987			2b. HOUR 4:10 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 10, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
13a. STATE MD.				13b. COUNTY HARFORD CO.		13c. CITY OR TOWN 21009	
14. FATHER'S NAME FIRST MIDDLE LAST SARGENT F. TATE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY A. SULLIVAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-32-1068		17. INFORMANT ADDRESS FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) ASHD w/ Bilateral Pleural Effusion APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH w/ 1 week CHF + Arterial Hypertension							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Cachexia, Diets, Multiple Myeloma Type II							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-31, 1986, to 1-11, 1987, that (I) (we) last saw the deceased alive on 1-11, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE mjl		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAZATIN, NANNAL		22e. ADDRESS PO Box 579 8 Low St, Aberdeen, MD 21001					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-14-1987		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE PAICVILLE BALTO. CO. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF MEMOIRIES				25a. DATE REC'D. BY REGISTRAR JAN 19 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall	

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

041703 JAN 23 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02142  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Vernon J. Kirby</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 17 87</b>		2b. HOUR P. M. <b>7:15 P.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 25 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>76</b>	IF UNDER 1 YEAR IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Fallston</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1204 Hillsboro Court Fallston</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto Upholster</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Klein Auto</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>		
13c. CITY OR TOWN <b>Fallston</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1204 Hillsboro Ct. Fallston 21047</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Kirby</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Winkle</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>216-03-9472</b>		17. INFORMANT ADDRESS <b>Verna Lashley 3206 Longwood Court 21084</b>		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CANCER TO LUNG</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CANCER OF LARYNX (RECURRENT)</b>		<b>23 months</b>
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2-13</b> , 19 <b>85</b> , to <b>1-17</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11-26</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>John R. Saunders MD</b>		22c. DATE SIGNED <b>1-19-87</b>	
22d. PRINT SURVIVOR'S NAME (TYPE OR PRINT) <b>JOHN R. SAUNDERS (337-5200)</b>		22e. ADDRESS <b>1001 Cromwell Bridge Rd. Suite 308</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1-20-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harford Maryland</b>
24. FUNERAL DIRECTOR NAME <b>E.F. LASSAHN F.H.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1987</b>	25b. REGISTRAR'S SIGNATURE <b>John Saunders-Randall</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in envelope with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, death was a result of an accident, or death was a result of a violent event, the medical examiner must be notified.





041906 JAN 28 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY M. LOETELL</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>22</b> YEAR <b>87</b>		2b. HOUR <b>1:30</b> PM			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>3</b> YEAR <b>08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.			
10. CITY OR TOWN OF DEATH <b>Pallston</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pallston Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Joppa</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE <b>1000 Greenfield Bl. 21085</b>	
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>T.</b> LAST <b>Wade</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Lena</b> MIDDLE <b>--</b> LAST <b>Goddard</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-32-8972-A</b>		17. INFORMANT ADDRESS <b>Joppa, Md. 21085</b> <b>Mrs. Louise Amrein, 1100 Hollingsworth Rd,</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE &gt; 10 YRS.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COR PULMONALE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>--</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>ACVD</b>									
19a. DATE OF OPERATION <b>--</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>--</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>--</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>--</b> CITY OR TOWN <b>--</b> COUNTY <b>--</b> STATE <b>--</b>					
22a. I certify that (I) (the undersigned) attended the deceased from <b>1/16/87</b> to <b>1/22/87</b> , that (I) (we) last saw the deceased alive on <b>1/22/87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>David R. Padriano</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/22/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID R. PADRIANO, M.D.</b>				22e. ADDRESS <b>1212 CHURCHVILLE RD., BEL AIR 21014</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 26, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Episcopal Cem., Abingdon</b>		23d. LOCATION CITY OR TOWN <b>Harford</b> COUNTY <b>Md.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III, Abingdon, Md. 21009</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 28 1987</b> <b>Julia Padriano</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMM - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



043542 FEB 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

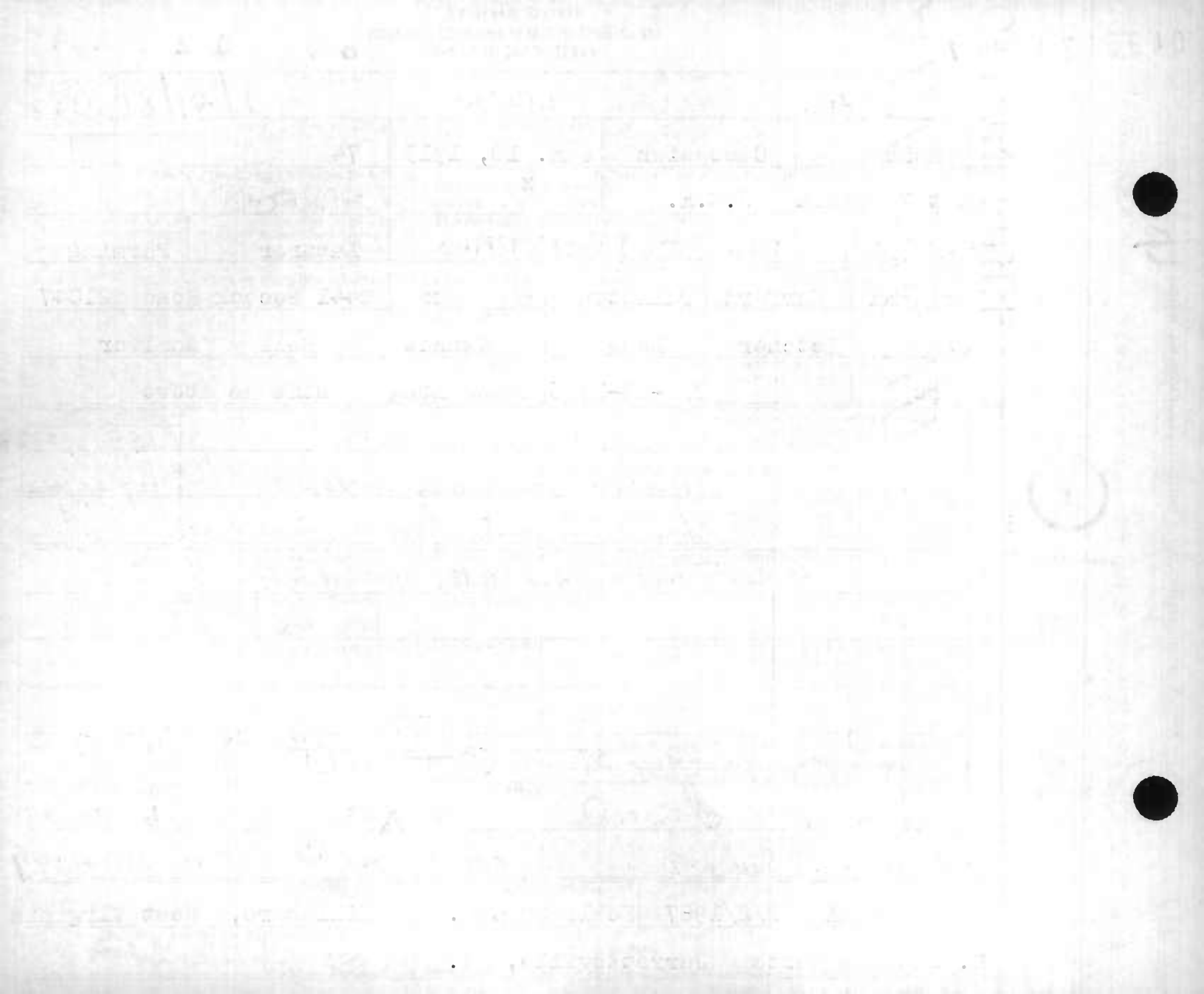
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please complete the other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18, state any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
FOR 1 - STATE REGISTRAR		87		02144		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR		
EARL			LONG			1			29			87			10 <sup>51</sup> AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR			IF UNDER 24 HRS		
Male			Caucasian			Jan. 10, 1913			74			YRS			MONTHS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
West Virginia			U.S.A.						HARFORD						MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
FALLSTON			FALLSTON GENERAL			Laborer			Farming								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE											
Maryland			Fallston			2441 Pockock Road			21047								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
John Letcher			Nannie Bell														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			232-24-3726			Agnes Long			same as above								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Shock with Cachexia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Respiratory failure, severe emphysema X years</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>General malnourished state, non-specific hepatitis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10<sup>51</sup> AM 1/29/87</u> <u>have no idea how long</u>							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) this hospital attended the deceased from <u>Jan. 26, 1987</u> to <u>Jan. 26, 1987</u> , that (1) (we) last saw the deceased alive on <u>Jan. 26, 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (2) we (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Albert S.C. Sun, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>Jan. 30, '87</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Albert S.C. Sun, M.D.</u>			22e. ADDRESS <u>1800 Harford Rd. Fallston, MD 21047</u>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>2/2/1987</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Kellison Cem.</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hillsboro, West Virginia</u>								
24. FUNERAL DIRECTOR NAME <u>M. Gladden Kurtz</u>			ADDRESS <u>Jarrettsville, MD</u>			25a. DATE REC'D. BY REGISTRAR <u>FEB 04 1987</u>			25b. REGISTRAR'S SIGNATURE <u>Julia Dindon-Rodgers</u>								

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove cause of death from pages 1 and 2 and place in the container for disposal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Verna Espenshane LOVELAND</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 - 3 - 87</b>			2b. HOUR <b>11 40 AM</b>			
3. SEX <b>F</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 6 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.			
10. CITY OR TOWN OF DEATH <b>Harre DeGrace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Earleville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>51 Park LA Hacks Point 21919</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Aaron S. Espenshane</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Etter</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT <b>Sadie Keen</b>		ADDRESS <b>2 Stemmer Run RD 21919</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1/3/87</b> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <b>1/3/87</b> to <b>1/4/87</b> , that (1) (we) last saw the deceased alive on <b>1/3/87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death)									
22b. SIGNATURE <b>JOAN P. EDWARDS, MD</b>			22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOAN P. EDWARDS, MD</b>			22d. ADDRESS <b>2112 BELAIR RD FALLS CHURCH, VA 22047</b>		22e. DATE SIGNED <b>1/4/87</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan 5, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephen's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Earleville Cecil MD</b>		
24. FUNERAL DIRECTOR NAME <b>Gary Fellows Box 270 Millington, MD</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 9 1987</b>				
25b. REGISTRAR'S SIGNATURE									

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) William Joseph Lowe, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 1-10-87			2b. HOUR 7:00 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-29-1905		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County Maryland MD.			
10. CITY OR TOWN OF DEATH Joppatown Harford Co.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 412 Breslin Rd., Joppatown, MD 21085				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police-Retired		12b. KIND OF BUSINESS OR INDUSTRY Balto. City	
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Joppatown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 412 Breslin Rd., Joppatown 21085	
14. FATHER'S NAME FIRST MIDDLE LAST Lowe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-10-4055		17. INFORMANT ADDRESS William J. Lowe, Jr., 412 Breslin Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BREAST CARCINOMA, METASTATIC</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Andrew Nowakowski MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD				22e. ADDRESS 125 N. MAIN ST. BELAIR					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-13-87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN Balto.		23e. COUNTY Balto., MD STATE	
24. FUNERAL DIRECTOR John C. Miller, Inc., 6415 Belair Rd. 21206				25a. DATE REC'D BY REGISTRAR JAN 14 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			





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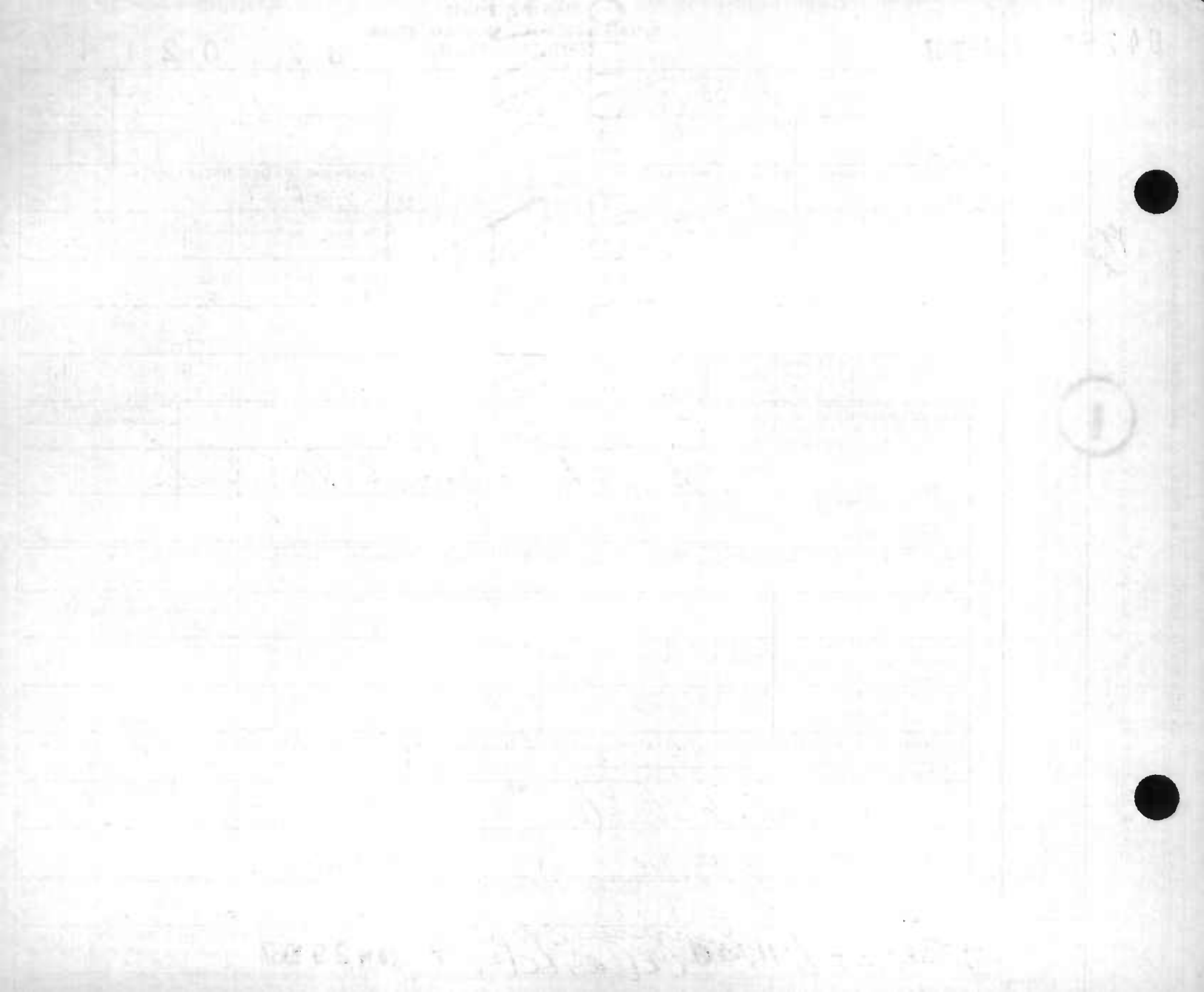
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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. The medical examiner's report, if any, should be filed with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's report should be filed at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>FRANK J. MARX</i>					20. DATE OF DEATH MONTH DAY YEAR <i>1 24 87</i>			20b. HOUR <i>11:13 PM</i>	
3. SEX <i>Male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 04 21</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.			
10. CITY OR TOWN OF DEATH <i>Fallston</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Foreman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Beth. Stl.</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE <i>Md.</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Pylesville</i>		13e. STREET ADDRESS / ZIP CODE <i>501 St. Marys Rd. 21132</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Marx</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Stack</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no W.W. II</i>				16b. SOCIAL SECURITY NO. <i>219-07-9168</i>		17. INFORMANT ADDRESS <i>Mrs. Regina M. Marx, Pylesville, Md. 21132</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Suspected Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>11 12 87</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>422</i>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>1122 19 87</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>1122 19 87</i> to <i>1122 19 87</i> , that (I) (we) last saw the deceased alive on <i>1122 19 87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Joseph Reinhardt</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>1-25-1987</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph Reinhardt M.D.</i>					22e. ADDRESS <i>Fallston Hos. Fallston</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1-28-1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Balto. Md.</i>		
24. FUNERAL DIRECTOR <i>Joseph H. Reinhardt</i>					25a. DATE REC'D. BY REGISTRAR <i>21087</i>				
25b. REGISTRAR'S SIGNATURE <i>John D. Gordon</i>					JAN 29 1987				



040555 JAN 13 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

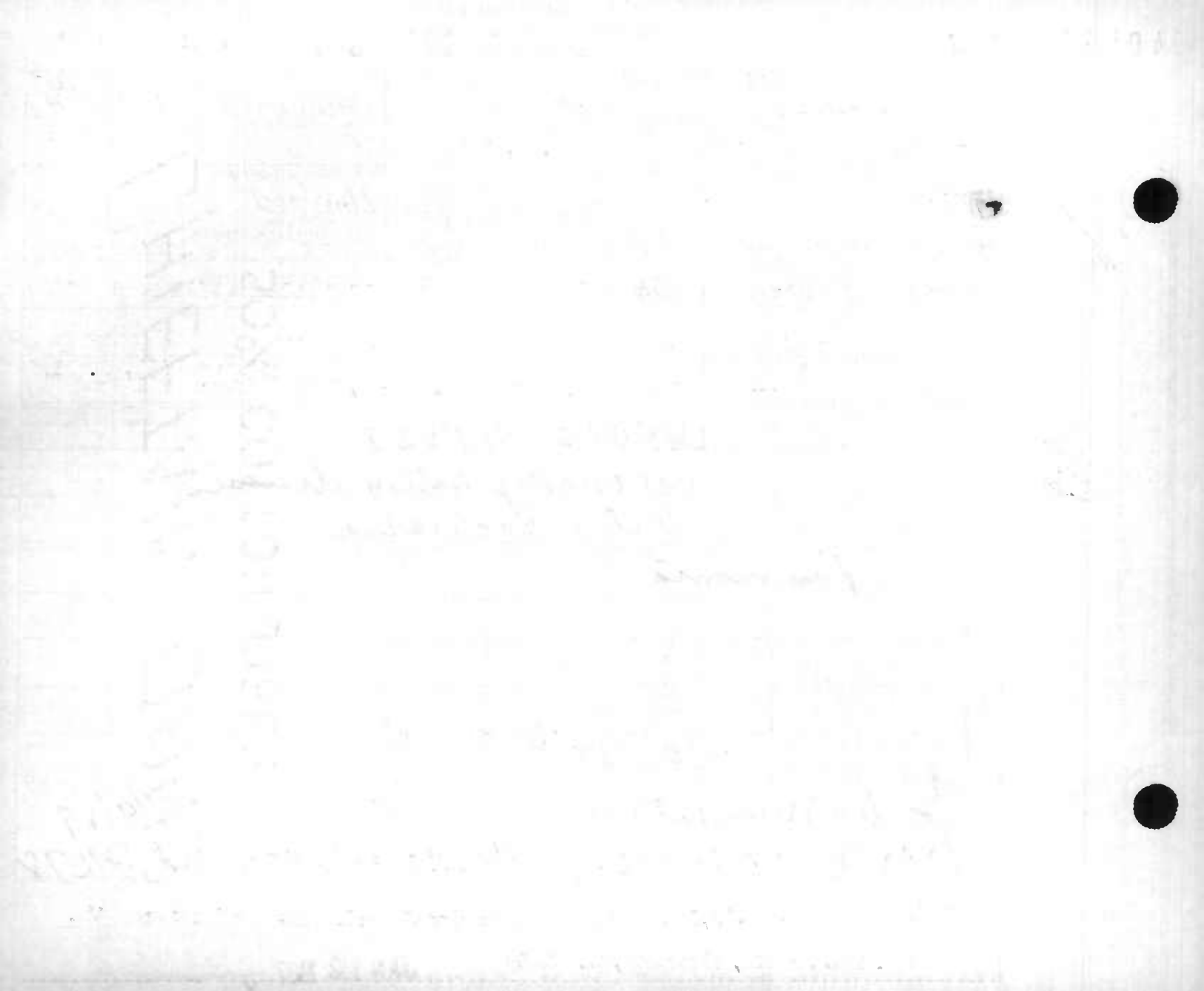
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please return completed pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be called at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Hallie</i>		FIRST <i>Hallie</i> MIDDLE <i>May</i> LAST <i>Mayor</i>		2a. DATE OF DEATH MONTH <i>January</i> DAY <i>9<sup>th</sup></i> YEAR <i>1987</i>		2b. HOUR <i>3<sup>45</sup> A.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>Nov.</i> DAY <i>3,</i> YEAR <i>1912</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.	
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) <i>Harford Memorial Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Steward</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Forest Hill</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <i>John</i> MIDDLE <i>Wesley</i> LAST <i>Harden</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Christina</i> MIDDLE <i>---</i> LAST <i>Kenney</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			
16b. SOCIAL SECURITY NO. <i>217-14-6361</i>		17. INFORMANT ADDRESS <i>Forest Hill, Md. 21050</i> <i>Norman E. Mayor, 1229 Walters Mill Road</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Pneumonia</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>12-31</i> <i>19</i> <i>86</i> <i>19</i> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12-31</i> <i>19</i> <i>86</i> , to <i>1-9</i> <i>19</i> <i>87</i> , that (I) (we) last saw the deceased alive on <i>1-9</i> <i>19</i> <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Daute M. Monakil</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/9/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAUTE MONAKIL</i>		22e. ADDRESS <i>Havre de Grace, Md 21078</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Jan. 12, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Arlington Va.</i>	
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III</i> ADDRESS <i>Abingdon, Md. 21009</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 12 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John A. ...</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward to the State Department of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Donald L. Mazor</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>12</b> YEAR <b>1987</b>			2b. HOUR <b>9:09</b> <sup>A.</sup> <sub>M.</sub>									
3 SEX <b>Male</b> <b>White</b>		4 RACE <b>White</b> <b>Male</b>		5 DATE OF BIRTH MONTH <b>June</b> DAY <b>9</b> YEAR <b>1922</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7 IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8 IF UNDER 24 HRS HOURS <b></b> MIN <b></b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Harford Co. MD.</b>									
10 CITY OR TOWN OF DEATH <b>Fallston</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston Gen. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Correction Officer Md. Penitentiary.</b>			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. CITY OR TOWN <b>Baltimore</b> 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13d. STREET ADDRESS <b>11817 Chapman Rd. 21087</b>									
14. FATHER'S NAME FIRST <b>Lewis</b> MIDDLE <b></b> LAST <b>Mazor</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Sophia</b> MIDDLE <b></b> LAST <b>Motivich</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>W.W. 11 215-16-2814</b>		17. INFORMANT <b>Mrs. Hazel A. Mazor, Kingsville, Md. 21087</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>12 years</b>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>head and chest injuries in 1972</b>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) <input checked="" type="checkbox"/> (his hospital) attended the deceased from <b>November 19 69</b> to <b>March 19 84</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>March 19 84</b> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.															
22b. SIGNATURE <b>Theodore E. Evans</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>1-12-87</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Theodore E. Evans, M.D.</b>						22e. ADDRESS <b>9660 Belair Rd., Balto. Md. 21236</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-15-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rossville Balto. Md.</b>							
24. FUNERAL DIRECTOR NAME <b>E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1987</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>						

MEDICAL CERTIFICATION

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02150  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John Lloyd McGeeney</b>		2a. DATE OF DEATH MONTH <b>1</b> DAY <b>1</b> YEAR <b>87</b>		2b. HOUR <b>10:25</b> P.M.
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>28</b> YEAR <b>99</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Fallston</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hosp</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SUPERINTENDENT</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>ARMCO STEEL</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE <b>md</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Forest Hill</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1701 Ross Rd 21050</b>
14. FATHER'S NAME FIRST <b>ROBERT</b> MIDDLE <b>E.</b> LAST <b>Mc GEENEY</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARGARET</b> MIDDLE <b>YOUNG</b> LAST <b></b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212 05 7682</b>		17. INFORMANT <b>GLORIA HALL</b> ADDRESS <b>21050</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b></b>				
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>1/1/87</b> to <b>1/1/87</b> , that (1) (we) lost saw the deceased alive on <b>1/1/87</b> , 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>R. Miller</b>		DEGREE <b></b>		22c. DATE SIGNED <b>1/2/88</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>FALSTON GENERAL HOSPITAL</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>1/5/1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. ANTHONYS CEMETERY</b>	23d. LOCATION CITY OR TOWN <b>EMMITSBURG</b>	COUNTY <b>MARYLAND</b>
24. FUNERAL DIRECTOR NAME <b>DIPPEL FUNERAL HOME 7110 BELAIR RD. BALTO. MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 2 1987</b>		
		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is ready to be filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place the certificate in the envelope provided and return it to the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial/cremation/removal. IMPORTANT: If item 21 is marked on item 8, shows any injury, or at any other event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		87		02151		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Mary M. McGonigal</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1-12-87</b>		2b. HOUR <b>2:30 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 26 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.			
10. CITY OR TOWN OF DEATH <b>Harre de Genee</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Aberdeen</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>611 Law Street / 21001</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Barney Lewis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marion Wright</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					
16b. SOCIAL SECURITY NO. <b>315-68-5194</b>		17. INFORMANT ADDRESS <b>Mr. Joseph E. Barkman Route 1 - Box 350AA Bogalusa, Louisiana</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RENAL FAILURE / UREMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIOPULMONARY ARREST</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>12 DAYS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>COMA</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>C. E. ECK</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/12/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES R ECK JR</b>		22e. ADDRESS <b>223 W. BELAIR AVE, ABERDEEN</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1-13-87</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE RECEIVED BY REGISTRAR	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. DATE RECEIVED BY REGISTRAR <b>JAN 16 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Dindon-Rudabaugh</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please attach to the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked as item 18, signs any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 02152

FOR 1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <u>Daniel Lloyd Miller</u>		2a. DATE OF DEATH MONTH DAY YEAR (Jan 20, 1987) - 20-87		2b. HOUR (P.M.) 1445 PM	
3. SEX <u>MALE</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR August 13, 1949		6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>West Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>HARFORD</u> MD.	
10. CITY OR TOWN OF DEATH <u>FALLSTON</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>FALLSTON GENERAL HOSPITAL</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Attendant</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Filling Station</u>	
13a. STATE <u>Maryland</u>		13b. CITY OR TOWN <u>Harford Co.</u>		13c. STREET ADDRESS / ZIP CODE <u>2700 Wilson Road 21154</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Ray OCEAL Miller</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ruby LEE Wilson</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>219-58-1640</u>	
17. INFORMANT (Mother) 836-1222 ADDRESS <u>Mrs Ruby L. Miller 2700 Wilson Road</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Death</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Medullary Collapse</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Massive Subarachnoid Hemorrhage</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION <u>1/18/87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cerebral Edema</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>87</u> , to <u>1/20</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Joseph William Foster</u>		DEGREE <u>Physician</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/20/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph William Foster</u>		22e. ADDRESS <u>Suite 102 1714 Harford Rd. Fallston Md 21047</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>January 23, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bel Air, Harford Co., Maryland 21014</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		ADDRESS <u>50 W. Broadway &amp; Williams St. Bel Air, Maryland 21014</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 29 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Tindon-Penderson</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. This page is not a coroner's report. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 02153			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Henry Miller				2a. DATE OF DEATH MONTH DAY YEAR 1 19 87				2b. HOUR 1355 PM			
3 SEX Male		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 3 18 22		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. COUNTY Harford		13c. CITY OR TOWN Bal Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 126 Fairmont Drive 21014	
14. FATHER'S NAME FIRST MIDDLE LAST William J. Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hoffman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Mrs. Patricia Miller - Same as #13		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Death</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Collapse</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebellar Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>OR</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/12</u> , 19 <u>87</u> , to <u>1/19</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/19/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Douglas Abbott</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/19/87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) J. Douglas Abbott				22f. ADDRESS Suite 102 1716 Harbor Blvd. Fallston							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 1-20-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 27 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

REG. NO.

02154

1. DECEASED NAME (TYPE OR PRINT) <b>Henry</b> <b>Harward</b> <b>Moulsdale</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-15-87</b>		2b. HOUR <b>4:20 PM</b>	
3 SEX <b>male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 7, 1900</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>86</b> YRS. MONTHS <b>1</b> DAYS <b>15</b> HOURS <b>4</b> MIN. <b>20</b>		
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fireman</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph</b> <b>---</b> <b>Moulsdale</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leanora</b> <b>---</b> <b>Harward</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US-govt. Ret.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-01-2251</b>		17. INFORMANT ADDRESS <b>Bel Air, Md. 21014</b>		
17. INFORMANT NAME <b>Marilee E. Moulsdale, 1103 Jeffrey Terrace,</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) <b>1) Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>2) CH of prostate</b> DUE TO, OR AS A CONSEQUENCE OF <b>3) CH of prostate</b> APPROPRIATE INTERVAL BETWEEN (a) AND (b) AND (b) AND (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.						
27a. SIGNATURE <b>John D. Yun MD</b>		DEGREE <b>MD</b>		27c. DATE SIGNED <b>1/15/87</b>		
27b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John D. Yun</b>		27e. ADDRESS <b>Havre de Grace, Md.</b>		27d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 18, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury U.M. Cemetery</b>		
23d. FUNERAL DIRECTOR NAME <b>Howard K. McComas III</b>		23e. ADDRESS <b>Abingdon, Md. 21009</b>		23f. LOCATION CITY OR TOWN COUNTY STATE <b>Abingdon Harford Md.</b>		
23g. DATE OF RECORD BY MEDICAL EXAMINER 23h. RECORDAR'S SIGNATURE <b>JAN 20 1987</b> <b>Julia Harrison Keadle</b>						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: # Item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_





040993 JAN 13

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

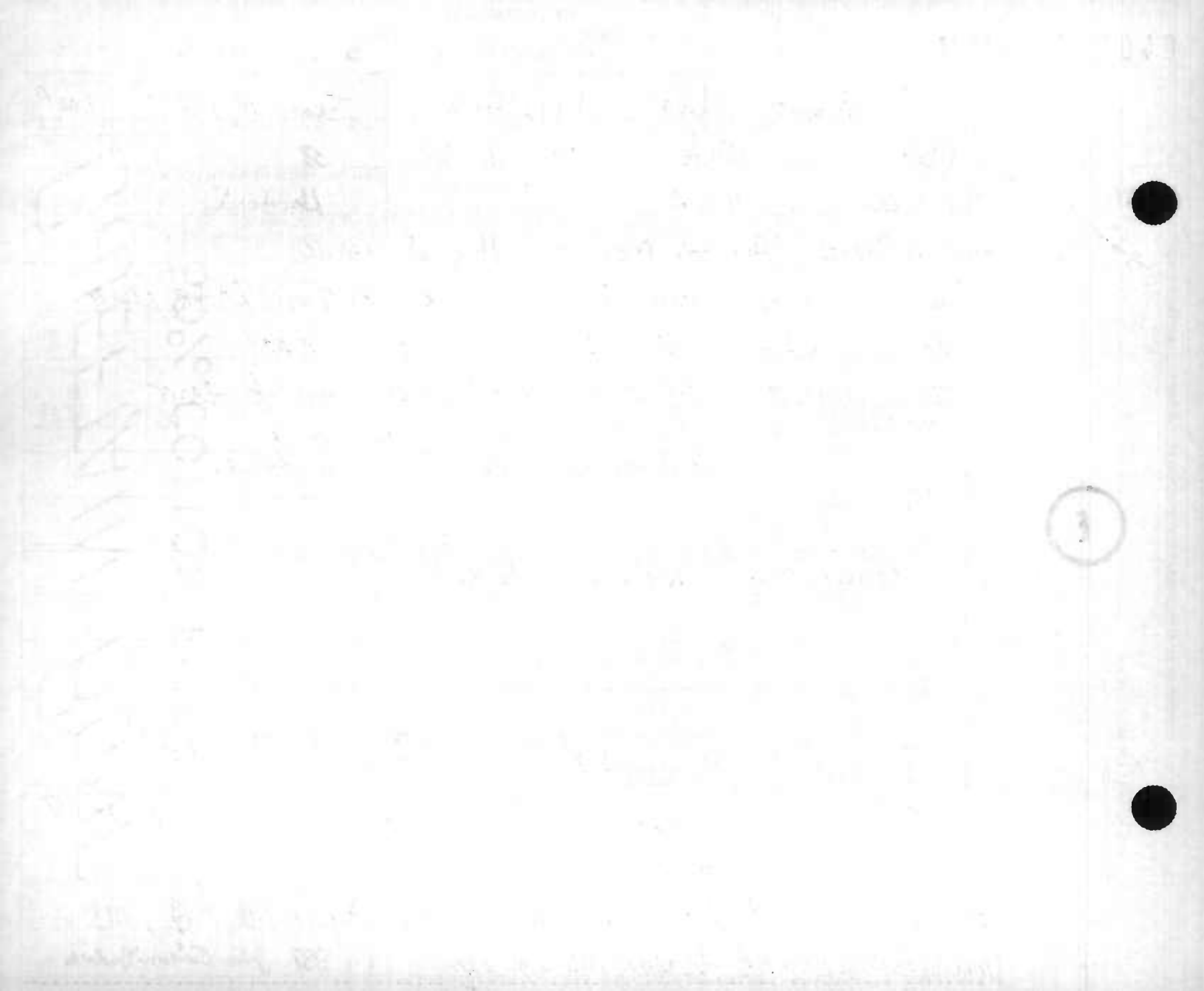
TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate remains the property of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 02155			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert Leo Mulford</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 10, 1987</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nor. 11, 1928</b>		2b. HOUR <b>9:00 P.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>58 YRS</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford MD.</b>	
10. CITY OR TOWN OF DEATH <b>Harford</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>				13b. CITY OR TOWN <b>Harford</b>		13c. STREET ADDRESS / ZIP CODE <b>901 QUARRY RD #8, /21078</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leo Shea Mulford</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cecelia Creagh</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>51-53 087-20-6415</b>		17. INFORMANT ADDRESS <b>D.A. MULFORD SAME AS ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung &amp; Metastasis to brain &amp; bone</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Congestive Heart Failure</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-4</b> , 19 <b>87</b> , to <b>1-10</b> , 19 <b>87</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Leticia J. Galvez</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-11-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leticia Galvez</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/14/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHELTENHAM MD. YET.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CHELTENHAM P.G. MD</b>	
24. FUNERAL DIRECTOR NAME <b>TARRING FUNERAL HOME P.A., ABERDEEN, MD, 21001-3399</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1987</b>			
				25b. REGISTRAR'S SIGNATURE <b>Julia Fenderson-Randall</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remain carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

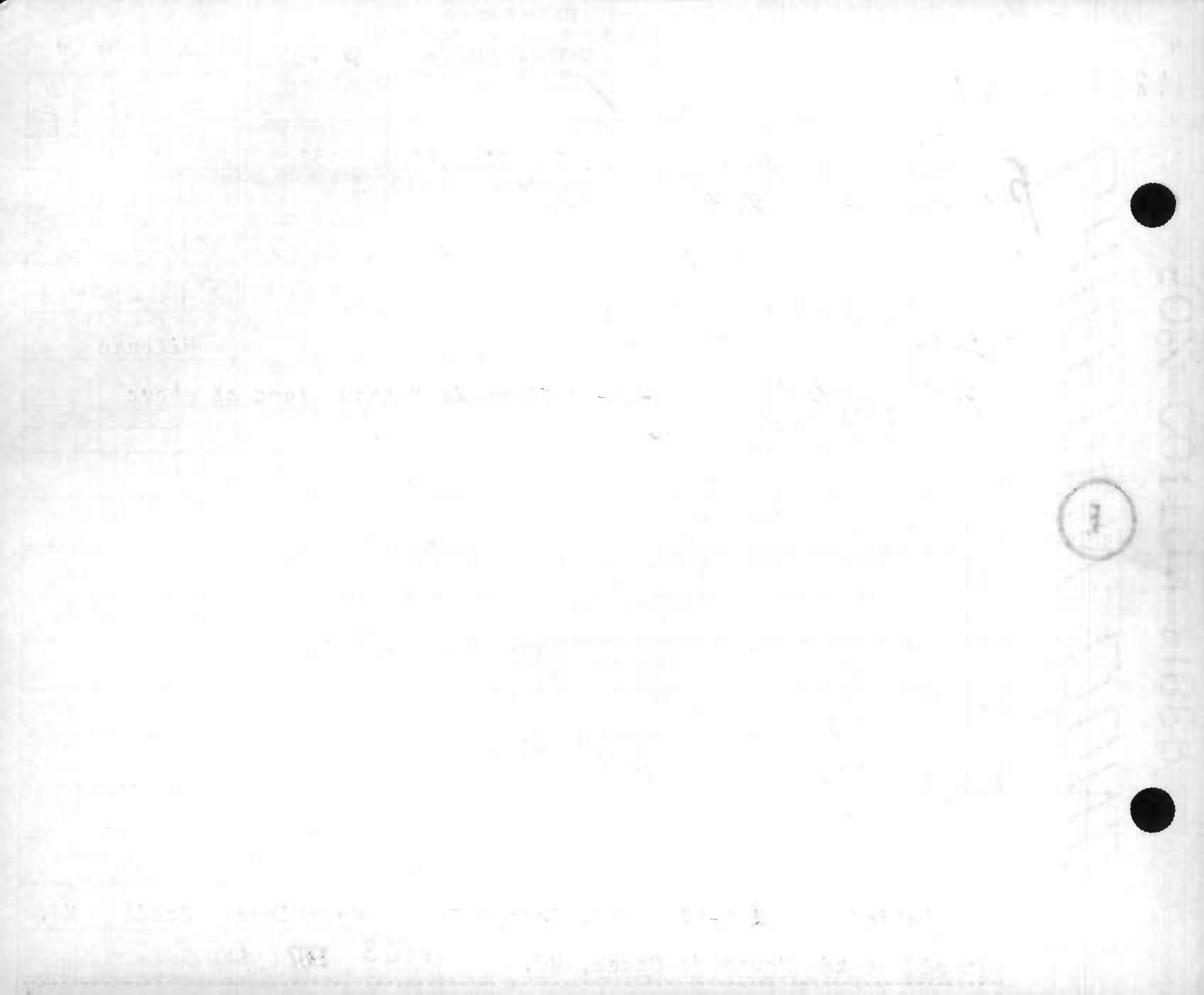
(IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.)

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 02159  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
ARTHUR			R.	Murray	JAN 23 1987					4 <sup>21</sup> PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 2 HRS		
Male	Black		MONTH DAY YEAR 3 31 27		59 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Pennsylvania	USA				Harford MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace		Harford Memorial Hosp				Retired		Civil Service			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.		Cecil		Port Deposit		YES <input type="checkbox"/> NO <input type="checkbox"/>		46 Old School House 21904			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
JEFF		MURRAY		Helen		197-20-2647		Luvenia Murray same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a)		Carotid aneurysm									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) Acute coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis heart strain									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT HOME AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-23, 1987, to 1-23, 1987, that (I) (we) last saw the deceased alive on 1-23, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED					
22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22d. DATE SIGNED							
TAMAKAWA M.D. 3195		5 Union Ave. Havre de Grace Md 21078		2/3/87							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY		23e. REGISTRAR'S SIGNATURE			
burial		2-2-87		Mt. Zoar AME		Conowingo Cecil Md.		Julia Swindon-Randall			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Arnold Beard Havre de Grace, Md.				FEB 3 1987							



42202

FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02157  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>James H. Nelson Jr.</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1/22 19 87</b> DEATH MATED <input type="checkbox"/>				2b. HOUR <b>9<sup>47</sup> AM</b>	
3. SEX <b>M</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 5 45</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>41 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>1/22 19 87</b>		7d. HOUR <b>10<sup>3</sup> AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b>			
10. CITY OR TOWN OF DEATH <b>Fallston</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Field Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NCR</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Joppa</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>504 Eckhart Ct. 7085</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES H. NELSON, SR.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GEORGIA PENN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>219 80 3229</b>		17. INFORMANT ADDRESS <b>Janice Nelson 504 Eckhart ct. 21085</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>ASCVD - Hypertension</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <b>Luis E. Renjel</b>				TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>1/23/87</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Luis E. Renjel, MD</b>				ADDRESS <b>464 Alliance St. Havre De Grace, MD</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>1/29/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOORELAND MEM. PK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>MARCH FUNERAL HOME 1101 E. NORTH AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Anderson-Randall</b>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE SECURED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25 AD



JAN 28 1981

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02158  
REG. NO.1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Julia <b>JULIA</b>		FIRST MIDDLE (nmn) Nyborg <b>NYBORG</b>		2a. DATE OF DEATH MONTH DAY YEAR 1-19-87		2b. HOUR 9:41 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 18, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Silk Warper		12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward -- Kuenzler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia -- Lenggenhager		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 138-54-3295	
17. INFORMANT Shirley C. Kuenzler		ADDRESS Bel Air, Md. 21014 309 Prospect Mill Rd.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a).

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b).

DUE TO, OR AS A CONSEQUENCE OF

(c).

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Andrew Nowakowski MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD		22e. ADDRESS 125 N. MAIN ST BEL AIR, MD 21014					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 21, 1987		23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE W. Chester Chester Pa.	
24. FUNERAL DIRECTOR Howard K. McComas II, Abingdon, Md. 21009				25a. DATE RECEIVED BY REGISTRAR'S SIGNATURE JAN 21 1987			

1-11-27 949

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100% COTTON



041942 JAN 20 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 02157

1. DECEASED NAME (TYPE OR PRINT) Joseph A. Opdyke			2a. DATE OF DEATH MONTH DAY YEAR Jan. 21, 1987			2b. HOUR P. M. 6:30				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-15-1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD.				
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston gen. hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cabinet maker		12b. KIND OF BUSINESS OR INDUSTRY Civil Service		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Md. Baltimore			13b. CITY OR TOWN Kingsville		13c. STREET ADDRESS 12008 Jerusalem Rd. 21087					
14. FATHER'S NAME FIRST MIDDLE LAST Orris J. Opdyke Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth M. Burns			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. W.W.11 220-14-5230	
17. INFORMANT ADDRESS Mrs. Dorothy E. Opdyke, 12008 Jerusalem Rd. Kingsville Md 21087										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>QSEVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10yo</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pulmonary Edema</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <u>1/17/87</u> 19 <u>87</u> , to <u>January</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>1/17/87</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>1/23/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D.A. Oursler, MD</u>			22e. ADDRESS <u>7401 Osler Dr</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-24-1987		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>AN 27 1987</u> <u>[Signature]</u>				

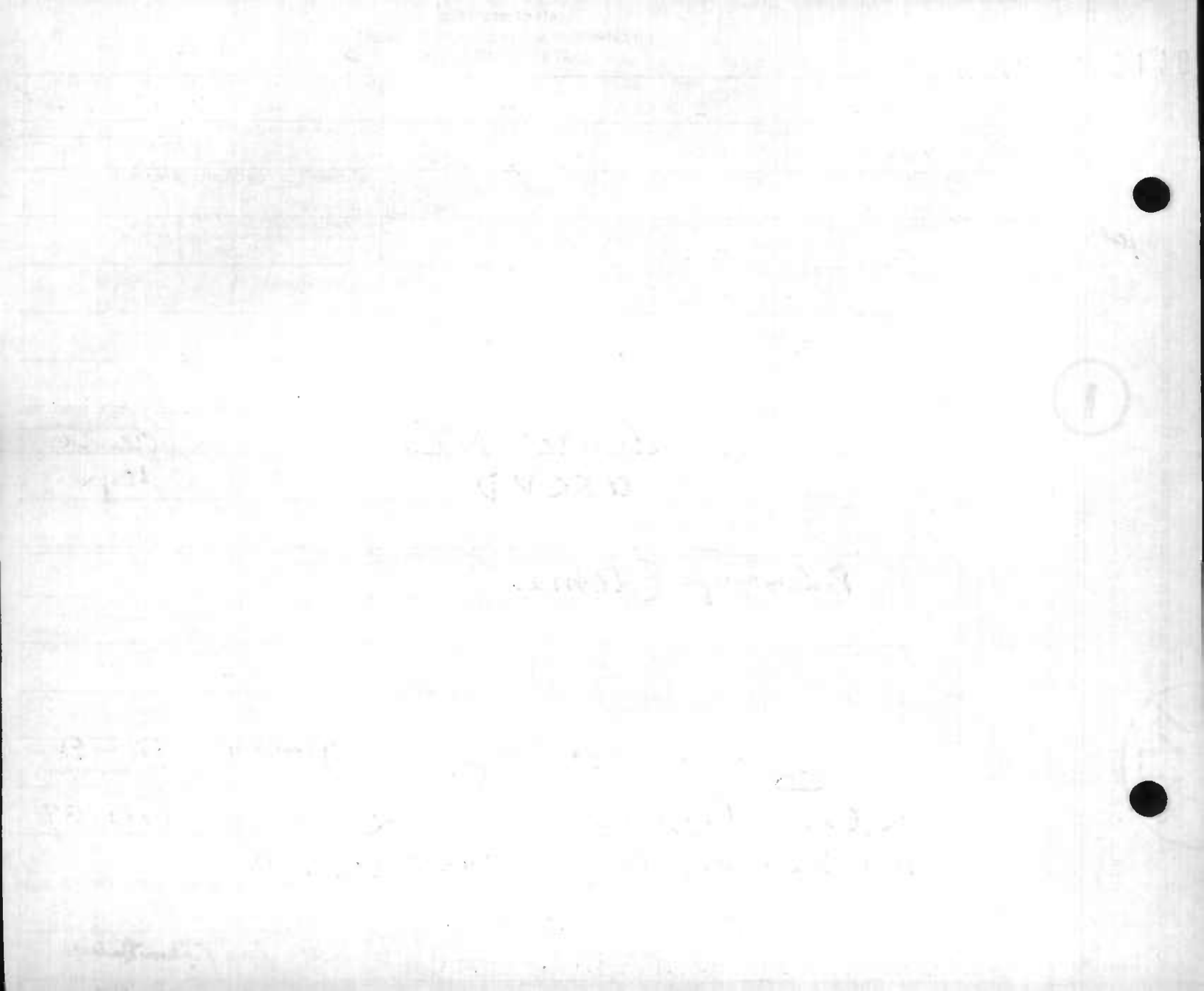
MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a separate report filed.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201



040553 JAN 18 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02160  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNA SCHIPANI PARELLO			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 9, 1987			2b. HOUR A M							
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 20, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.							
10. CITY OR TOWN OF DEATH HAVRE de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 712 TYDING ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) CASHIER			12b. KIND OF BUSINESS OR INDUSTRY FEO GOVT (APG)				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MO			13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 712 TYDINGS ROAD 21078				
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH SCHIPANI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARMELLA TUCCIRELLI									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 069 28 8167		17. INFORMANT ADDRESS MRS. MILOREO CIANELLI, 1002 LESLIE RD HdG, MD 21078								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic adenocarcinoma of brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Primary never ascertained</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> 19 <u>84</u> to <u>1/9</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/31</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>L. Silverstein</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>1/9/86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. SILVERSTEIN, M.O.				22e. ADDRESS 203 SOUTH WASHINGTON ST. HAVRE de GRACE, MO. 21078									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12 JANUARY 87		23c. NAME OF CEMETERY OR CREMATORY MT. ERIN CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MO					
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078						25a. DATE REC'D BY REGISTRAR JAN 12 1987						25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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042521 FEB-1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 02161

1. DECEASED NAME (TYPE OR PRINT) Adeline Anna Parris			2a. DATE OF DEATH MONTH DAY YEAR 1-23-87		2b. HOUR 3:30 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 7 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) Cleveland, Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALSTON GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY Home keeping
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.			13b. COUNTY Harford	13c. CITY OR TOWN Belair	
14. FATHER'S NAME FIRST MIDDLE LAST Theodore Goepfert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Weismiller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-01-3140		17. INFORMANT ADDRESS Presley D. Parris, Belair, Md. 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PROBABLE CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD - severe</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>YEARS</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> 19 <u>87</u> to <u>1/23</u> 19 <u>87</u> , that (I) (we) lost <u>yes</u> the deceased alive on <u>yes</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE MD		22c. DATE SIGNED 1-23-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY A. WOTZ MD		22e. ADDRESS 2003 ROCK SPRING RD. FALSTON MD. 21050			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-26-1987	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Baltimore Md.	
24. FUNERAL DIRECTOR NAME E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087		25a. DATE REC'D. BY REGISTRAR JAN 29 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. These permits remain with the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner should be notified at once.

BP



409 JAN 16 1987

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02102

1. DECEASED NAME (TYPE OR PRINT) <b>RONALD Eugene Phinney</b>			7a. DATE KNOWN OF DEATH ESTIMATED <b>19 1987</b>			7b. HOUR <b>M</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 12 1954</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>32 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>19 1987</b>	7d. HOUR <b>6:26 PM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HAVRE DE GRACE MD.</b>			
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HARFORD Memorial</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Brick Layer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lane Masonry</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Cecil</b> 13c. CITY OR TOWN <b>Perryville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>645 Cole Street</b>		Construction <b>21903</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alton E. Phinney</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy Bailey</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-684 352</b>		17. INFORMANT ADDRESS <b>Hospital Records</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE INJURIES</b> 8199 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <b>car accident.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Luis E. Renjel</b>			TITLE (SPECIFY) <b>Deputy</b>			MEDICAL EXAMINER		DATE SIGNED <b>1-10-87</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Luis E. Renjel</b>			ADDRESS <b>464 Alliance St Havre de Grace 21077</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 13, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Colora Cecil Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Lee A. Patterson &amp; Son</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1987</b>			25b. REGISTRAR'S SIGNATURE <b>Julia S. Davidson-Randall</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

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NOV 21 1954

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040548 JAN 18 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 02163  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter John Pirog Sr.			2a. DATE OF DEATH MONTH DAY YEAR Jan. 8, 1987		2b. HOUR 10:15 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9-6-1925	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD.		
10. CITY OR TOWN OF DEATH Kingsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2705 Reckord Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed	12b. KIND OF BUSINESS OR INDUSTRY Auto Paintg.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Kingsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2705 Reckord Rd. 21087	
14. FATHER'S NAME FIRST MIDDLE LAST John Pirog		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Szczy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 219-10-2668	17. INFORMANT ADDRESS 2705 Reckord Rd. Mrs. Dorothy H. Pirog, Kingsville, Md. 21087		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Crownary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic cardiovascular disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Mellitus</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 15, 1987</u> to <u>JAN. 8, 1987</u> , that (I) (we) lost saw the deceased alive on <u>DEC. 17, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Benoletza</u>		22c. DEGREE MD	22d. DATE SIGNED 1/9/87		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) BEN OTEY ZA		22f. ADDRESS 846 S. MAIN ST., BEL AIR, MD. 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-10-1987	23c. NAME OF CEMETERY OR CREMATORY Highview Mem. Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Fallston Harford Md.		
24. FUNERAL DIRECTOR NAME ADDRESS E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087		25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE Julia Benson-Randall	

MEDICAL CERTIFICATION

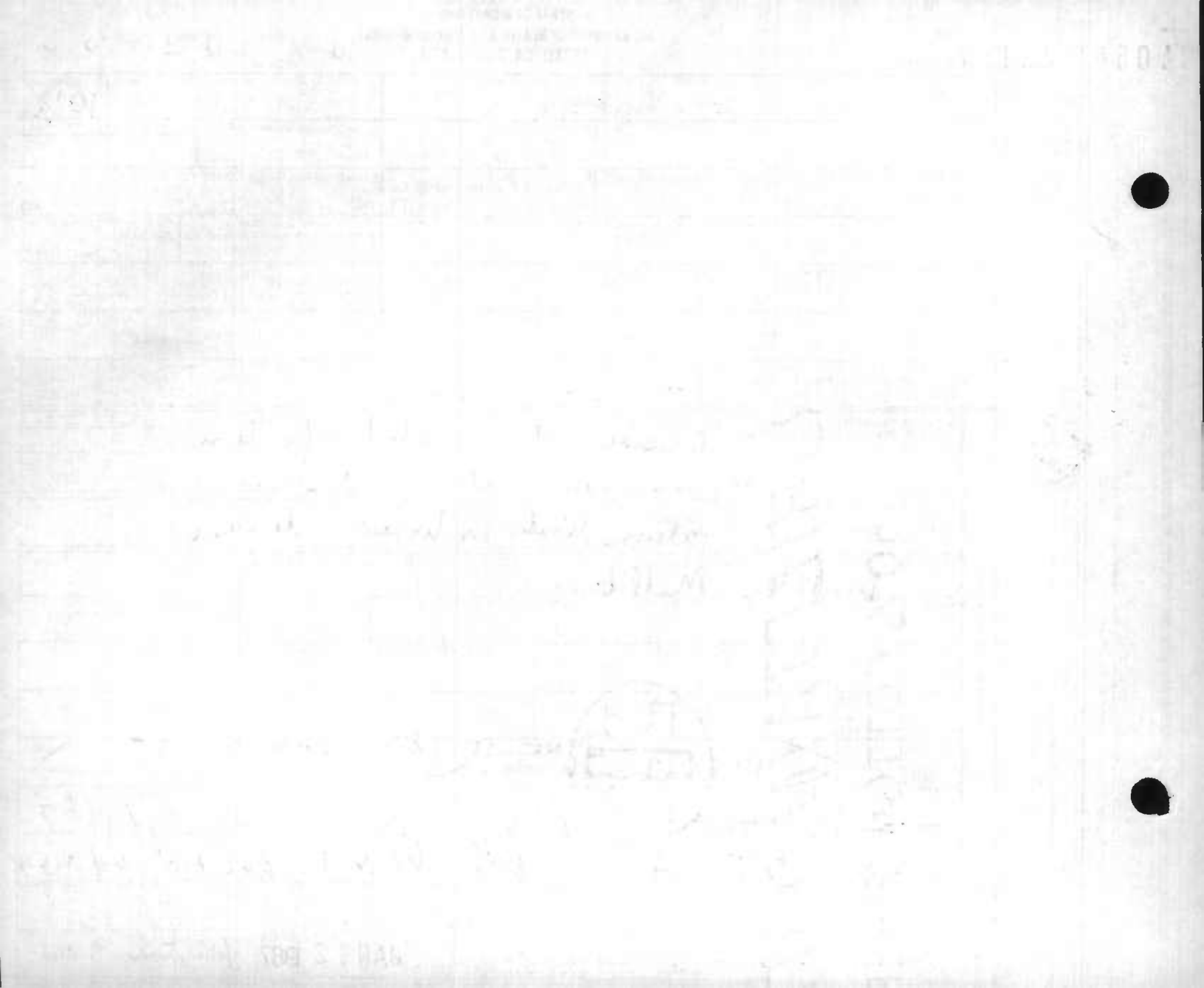
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner must be notified of once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02164  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Julia Ann Pohlman			2a. DATE OF DEATH MONTH DAY YEAR January 10, 1987			2b. HOUR 10 A M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR July 3, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co., MD.	
10. CITY OR TOWN OF DEATH Bel Air, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15 Dallam Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Eierman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Dittmar			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213 05 4187		17. INFORMANT ADDRESS Mr. George Pohlman 552 Hampton Ln. -04			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ADENOCARCINOMA - METASTATIC</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>&gt; 6mm</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 19 to 19, that (1) (we) lost view the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Edwards				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN I. EDWARDS				22e. ADDRESS 2112 BEL AIR RD BALTIMORE MD 21047			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/13/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.				ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR JAN 14 1987	
25b. REGISTRAR'S SIGNATURE Julia Division-Randa							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 6 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.



040616 JAN 1987

DIVISION OF VITAL RECORDS - 201 W. PRESTON ST., BALTIMORE, MD. 21201

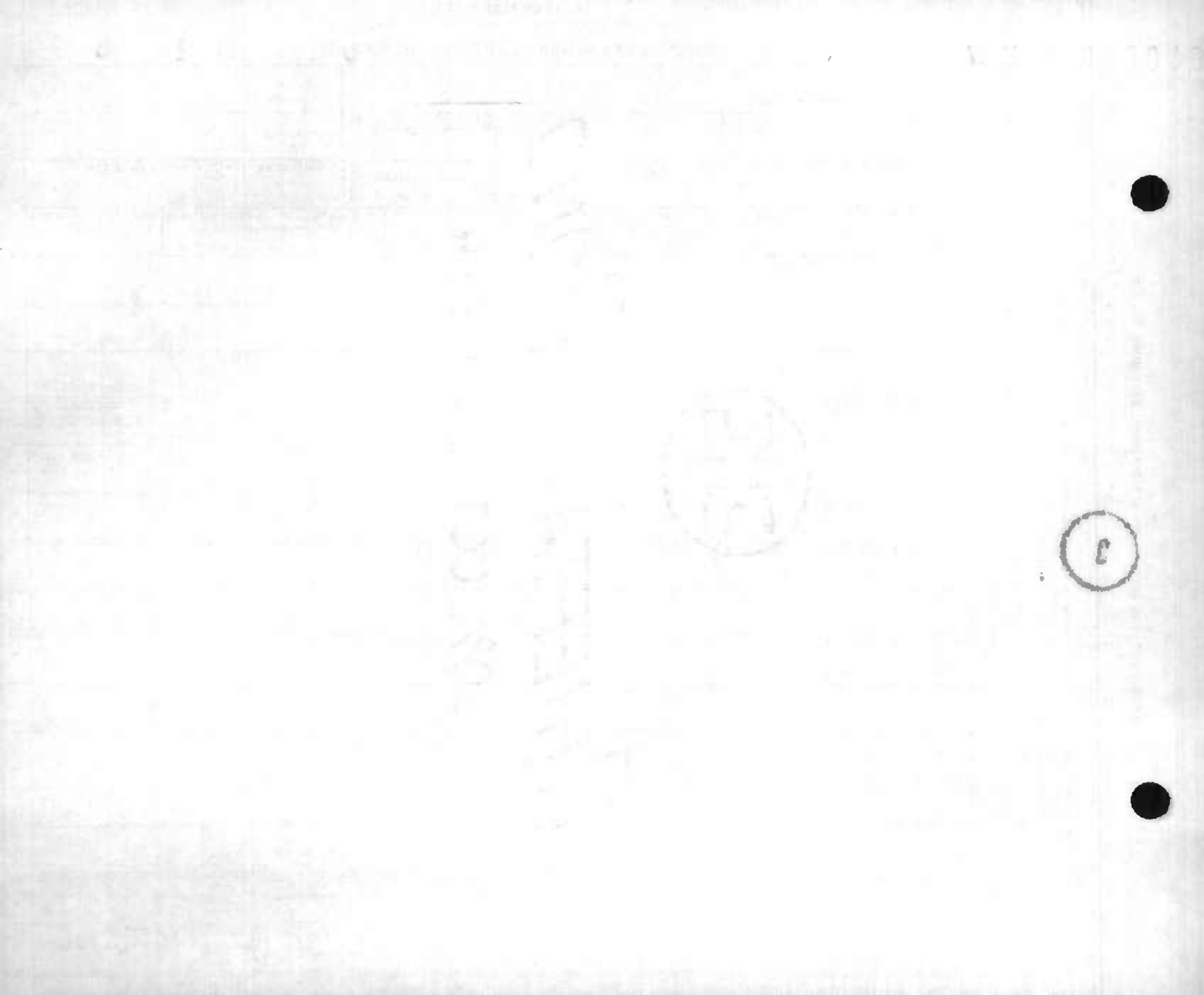
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02165

1. DECEASED NAME (TYPE OR PRINT)		FIRST CHALMERS RANDOLPH		MIDDLE V.		LAST RANDOLPH <del>CHALMERS</del>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 1 1987		2b. HOUR M 12:01 A	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 3 37		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 1 1987		2d. HOUR M 12:01 A	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.											
13b. CITY Harford		13c. CITY OR TOWN Joppatown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 340 Adair Court 21085					
14. FATHER'S NAME FIRST MIDDLE LAST Vaughn F. Randolph				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Annette Manger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-32-8951		17. INFORMANT ADDRESS Mrs. Marlene J. Randolph - Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Pulmonary emphysema</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY STREET, FACTORY, FARM, ETC. HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Charles P. Kokes</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1-3-87			
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn St., Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 1-5-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board						ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Sander-Rudolf</i>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 08-47-9100

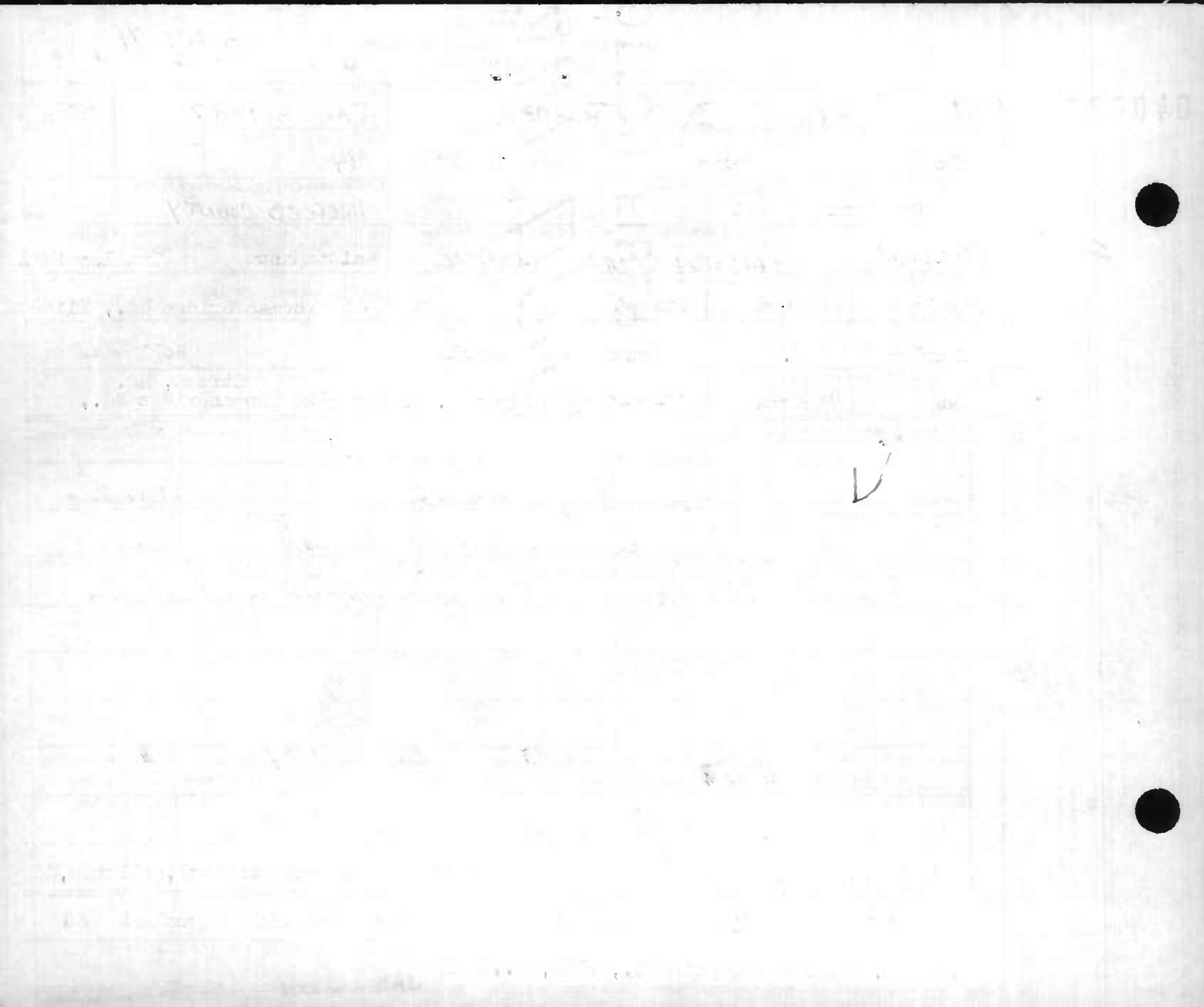
1. DECEASED NAME (TYPE OR PRINT) <b>Joseph D. RAYNER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 8, 1987</b>		2b. HOUR <b>500 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 12 1942</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Trailer Park</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Street</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3426 Thomas Bridge Rd., 21154</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles W. Rayner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stella Robinette</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes Vietnam</b>		16b. SOCIAL SECURITY NO. <b>215-40-1473</b>		17. INFORMANT ADDRESS <b>Street, Md.</b> <b>Linda C. Duncan 3426 Thomas Bridge Rd.,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemorrhagic shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Tumor invasion of bowel</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>hours</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Renal cell carcinoma - disseminated metastasis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/7/87</b> , 19 <b>86</b> , to <b>1/8/</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>1/7/87</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Walter Zunker</b>		DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Walter Zunker</b>		22e. ADDRESS <b>Fallston General Hospital, Fallston, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/12/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gdns</b>	
23d. LOCATION CITY OR TOWN <b>Bel Air</b>		COUNTY <b>Harford</b>		STATE <b>Md</b>	
24. FUNERAL DIRECTOR NAME <b>John H. Harkins</b>		ADDRESS <b>600 Main St., Delta, Pa., 17314</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>John H. Harkins</b>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item (a) show any injury, or other traumatic event, the medical examiner may be notified of once.





40770 JAN 18 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02161  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Agnes Loretta Rertz</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 10 87</i>		2b. HOUR <i>5:58 PM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>June 8, 1917</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Delaware</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD COUNTY</i> MD.	
10. CITY OR TOWN OF DEATH <i>FALLSTON</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FALLSTON GENERAL HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Jarrettsville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>1380 North Bend Road 21084</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William M. Kelly</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Catherine A. Fitzmaurice</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-10-8073</i>		17. INFORMANT ADDRESS <i>Judith A. Muhl 1380 North Bend Rd. 21084</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO PULMONARY ARREST</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute MI</i>		<i>day</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe CAD</i>		<i>year</i>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: *Chronic Obstructive Pulmonary Disease*

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Barry A. Wolt</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>1-11-87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Barry A. Wolt</i>		22e. ADDRESS <i>2003 Rockspring Rd Forest Hill, MD 21050</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>1-14-87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 18 1987</i>	25b. REGISTRAR'S SIGNATURE <i>John F. ...</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Their plates require carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified.



41281 JAN 20 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02108  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Bobby F. Rising</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1 13 87</b>		2b. HOUR <b>9<sup>20</sup> PM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 14 1938</b>		6 AGE (IN YEARS (LAST BIRTHDAY)) <b>48</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY MD</b>
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GEN. HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Inspector</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Co.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>Md. Baltimore</b>		13b. CITY OR TOWN <b>Perry Hall</b>	13c. STREET ADDRESS / ZIP CODE <b>12 Foxhill Court 21128</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wilbur Rising</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Stabler</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-34-8276</b>	17 INFORMANT ADDRESS <b>JoAnne Rising (wife) same address</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				2 WEEKS
DUE TO, OR AS A CONSEQUENCE OF (b) <b>INTRACEREBRAL HEMORRHAGE</b>				YEARS
DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from <b>1/1</b> 19 <b>87</b> , to <b>1/13</b> 19 <b>87</b> , that (we) last saw the deceased alive on <b>1/13</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we did not view the body after death, so state).				
22b. SIGNATURE <b>John Merillat MD</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/13/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN MERILLAT MD</b>		22e. ADDRESS <b>FALLSTON GENERAL HOSPITAL</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>1/14/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24 FUNERAL DIRECTOR <b>Schilmunek Funeral Home, Inc.</b> ADDRESS <b>9705 Belair Rd., Balto. Md. 21236</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 16 1987</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>	

MEDICAL CERTIFICATION

279

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by medical physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please mail to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified before burial, cremation, or entombment.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 02169

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Myrtle B. Rumburg			2a. DATE OF DEATH MONTH DAY YEAR JAN 1 1987		2b. HOUR 4 <sup>50</sup> P <sup>M</sup>
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Nov. 12, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN Harford		
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS / ZIP CODE 506 N. ADAMS ST. 21001		
14. FATHER'S NAME FIRST MIDDLE LAST Joe Whittaker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Helsel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO N/A		16b. SOCIAL SECURITY NO. 578-30-3237		17. INFORMANT ADDRESS Donald J. Laye, 2601 Fox Hollow Rd., Churchville MD, 21028	
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cecetic pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-21, 1986, to 1-1, 1987, that (I) (we) lost saw the deceased alive on 1-1, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (he) (she) (it) (did) (not) view the body after death.					
22b. SIGNATURE John D. Yun		DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 1/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Yun		22e. ADDRESS Havre de Grace, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 5, 1987		23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gdns.	
23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen, Harford, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399		25a. DATE REC'D. BY REGISTRAR JAN 8 1987		25b. REGISTRAR'S SIGNATURE Arlene Tarrington-Pickens	

BP

Great Highway Collection  
Assault

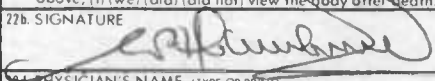
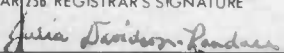
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the or medical examiner and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 02170  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Maria Rose Santagata			2a. DATE OF DEATH MONTH DAY YEAR January 9, 1987		2b. HOUR 6:45 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH May 10, 1951	6. AGE (IN YEARS LAST BIRTHDAY) 35	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10. CITY OR TOWN OF DEATH Forest Hill	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 234 Aster Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fiscal Clerk.	12b. KIND OF BUSINESS OR INDUSTRY State Govt.	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Forest Hill	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 234 Aster Lane 21050	
14. FATHER'S NAME FIRST MIDDLE LAST Angelo Charles Matranga		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Semilia			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None	17. INFORMANT ADDRESS Md. 21050 Keith F. Santagata, 234 Aster Lane, Forest Hill		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalised CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (b) from Cancer of the Appendix DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Constantinos P. Chilimindris, M.D. 6701 N. Charles St., Baltimore, Md.		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Jan. 10, 1987	23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE W. Chester Chester Pa.	24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009	
25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		37		02171		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Blanche Rosemont Saunders Blanche R Saunders				2a. DATE OF DEATH MONTH DAY YEAR 1-16-87		2b. HOUR 1144P M			
3. SEX Female		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 10 06 08		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker		12b. KIND OF BUSINESS OR INDUSTRY School			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1502 Westview Court 21014	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Abraham McLain				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Ellen Montgomery					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 227-03-5212		17. INFORMANT ADDRESS Claire P. Roz, 1502 Westview Court, Bel Air, Md. 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured Aortic Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) Atrial Septic Venular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.									
22b. SIGNATURE George Lawson MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) George Lawson MD				22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 20, 1987		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem.		23d. LOCATION CITY OR TOWN Joppa		23e. COUNTY STATE Harford Md.	
24. FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR JAN 21 1987					

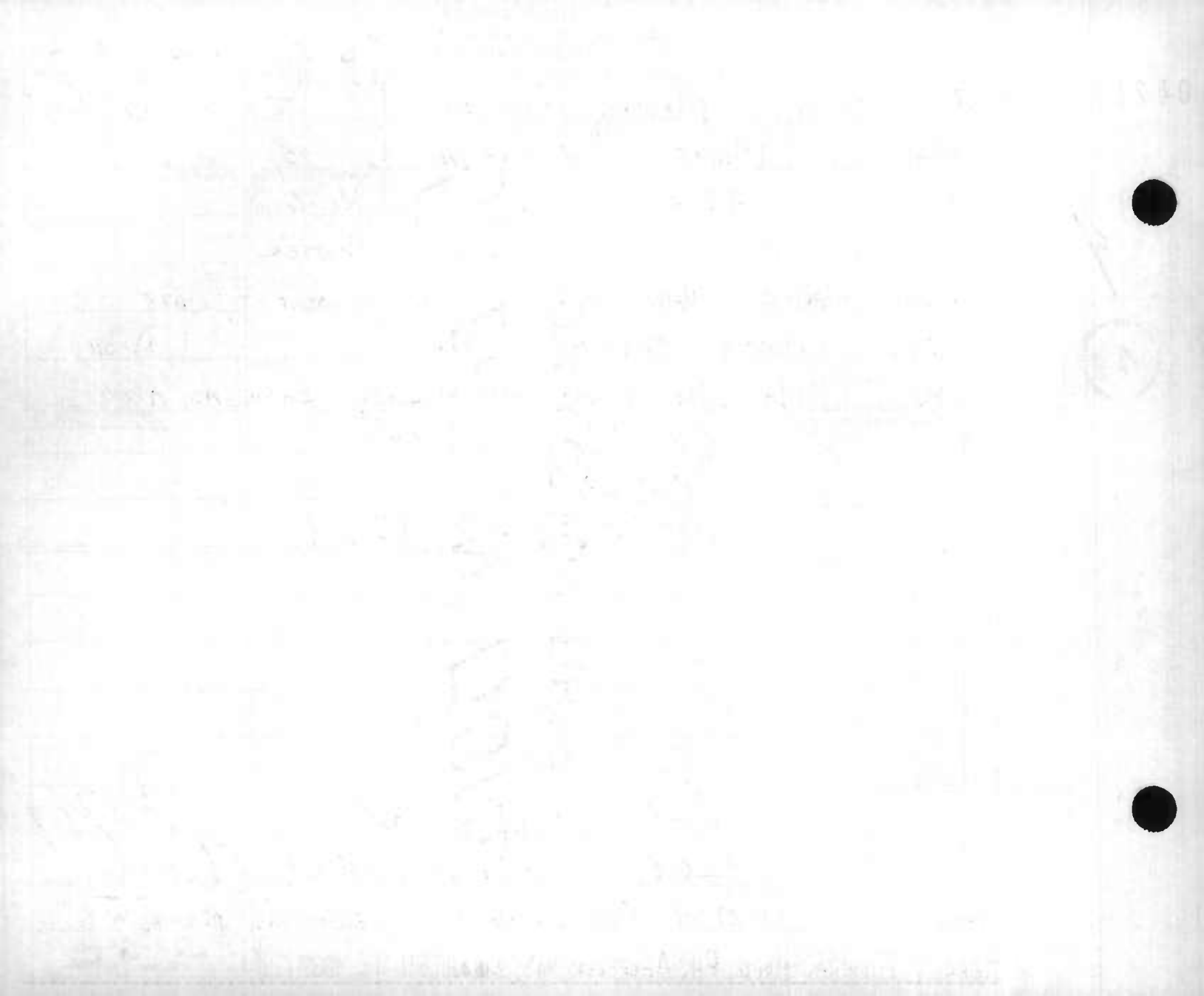


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. This certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner will be notified and the medical certificate will be subject to review.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 02172 REG. NO.	
1. DECEASED NAME FIRST MIDDLE LAST OREN MANNINS SAUNDERS						2a. DATE OF DEATH MONTH DAY YEAR Jan. 27 1987			2b. HOUR 9:26 P		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 - 4 - 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND						13b. COUNTY HARFORD		13c. CITY OR TOWN HAYRE DE GRACE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST OTIS MONROE SAUNDERS						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAMIE NASH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT ADDRESS JOYCE MILEKER - SAME AS ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>As COPD D.M.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. Lee M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Lee				22e. ADDRESS Union Med. Clinic							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1-29-87		23c. NAME OF CEMETERY OR CREMATORY GREENSBORO CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE GREENSBORO, CAROLINE, MD			
24. FUNERAL DIRECTOR NAME TARRING FUNERAL HOME, PA, ABERDEEN, MD, 21001				ADDRESS FEB 2 1987		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Julia Jordan			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02173  
REG. NO.FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Donald Raymond Schultz</b>			2a DATE OF DEATH MONTH DAY YEAR <b>1 7 87</b>		2b HOUR <b>304</b> M
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>July 17, 1933</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD	
10 CITY OR TOWN OF DEATH <b>FALLSTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GENERAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Beth Steel</b>
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD.</b>			13b COUNTY <b>Harford</b>		13c CITY OR TOWN <b>Fallston</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Willard Schultz</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Burfield</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korean 181-24-4418</b>		17. INFORMANT ADDRESS <b>Helen R. Schultz, same as above</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>1986</b> to <b>1-7-</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>12-23-</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.					
22b SIGNATURE <b>[Signature]</b> MD				22c DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>				22e ADDRESS	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1/9/87</b>		23c NAME OF CEMETERY OR CREMATORY <b>North Bend Cemetery</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>Renova, Clinton Co., Pa</b>		23e DATE REC'D. BY REGISTRAR			
24 FUNERAL DIRECTOR NAME <b>SCHIMUNEK FUNERAL HOME,</b>		25a REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

LIBRARY



NO. 101

NO. 101



042680 FEB 30

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 02174	
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE WASHINGTON SHIPLEY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1-23-87</b>			2b. HOUR <b>9:28 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 22, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>HARVE DE GRACE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HARFORD MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Manufact.</b>			
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Aberdeen</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Shipley</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Shipley</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>212-28-4363</b>		17. INFORMANT ADDRESS <b>Grace, MD, 21078 Loretta Gebhart, 444 Robin Hood Rd., Havre de</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Wm. Camacho MD</b>				DEGREE				22c. DATE SIGNED <b>1/23/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E.M. CAMACHO MD</b>				22e. ADDRESS <b>131 S. UNION AVE, HARVE DE GRACE MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/27/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gdns.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air, Harford, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

BP \_\_\_\_\_ n

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked as item 18 shows any other traumatic event, the medical examiner must be notified in advance.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 02175	
1. DECEASED NAME (TYPE OR PRINT) <b>FIRST Gordon MIDDLE Henry LAST STEMLER</b>			7a. DATE OF DEATH MONTH DAY YEAR <b>January 23, 1987</b>		7b. HOUR <b>1149</b> M.
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 15, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>FANSTON (2047)</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FANSTON GENERAL Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>utility</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford Co.</b>	13c. CITY OR TOWN <b>Bel Air</b>	13d. STREET ADDRESS / ZIP CODE <b>317 Wakefield Place 21014</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Andrew</b> LAST <b>Stemler</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Hilda</b> MIDDLE <b>Beckenheimer</b> LAST <b>Beckenheimer</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-05-4423</b>		17. INFORMANT (NAME) <b>Mrs. Doris U. Stemler</b> ADDRESS <b>317 Wakefield Place Bel Air, Maryland 21014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hour</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div>             DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Coronary Artery Disease</b> </div> <div>             DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCID</b> </div> </div>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>SIP Abdominal Aortic Aneurysm</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1/23 1987</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/23 1987</b> , to <b>1/23 1987</b> , that (I) (we) last saw the deceased alive on <b>1/23 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Barry Wohl</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-23-87</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY WOHL</b>		22c. ADDRESS <b>2003 ROCKSPRINT Rd FANSTON Hill, MD 21050</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 26, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air, Harford Co., Maryland 21014</b>		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE <b>JAN 28 1987 [Signature]</b>			
24. FUNERAL DIRECTOR <b>JOSEPH WILLIAM FOSTER</b> <b>50 W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>					



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be forwarded for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND										
DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO. 8702176										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary A. Stockwell			2a. DATE OF DEATH MONTH DAY YEAR January 15 1987				2b. HOUR 10 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 19 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.				
10. CITY OR TOWN OF DEATH Joppatowne		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 608 Apt. B Riley Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Joppatowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 608 Apt B Riley Ct. 21085	
14. FATHER'S NAME FIRST MIDDLE LAST Anton Smolocich					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Babich					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 356-12-5041		17. INFORMANT ADDRESS Stanley Stockwell (husband) address same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Cerebrovascular</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>D. Schlott</u>					DEGREE no			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Schlott					22e. ADDRESS 9 E. Chase St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/19/87		23c. NAME OF CEMETERY OR CREMATORY Ascension Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Libertyville, Lake Co.			
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home Inc. 9705 Belair Rd., Balto. Md. 21236						25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE Illinois		

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

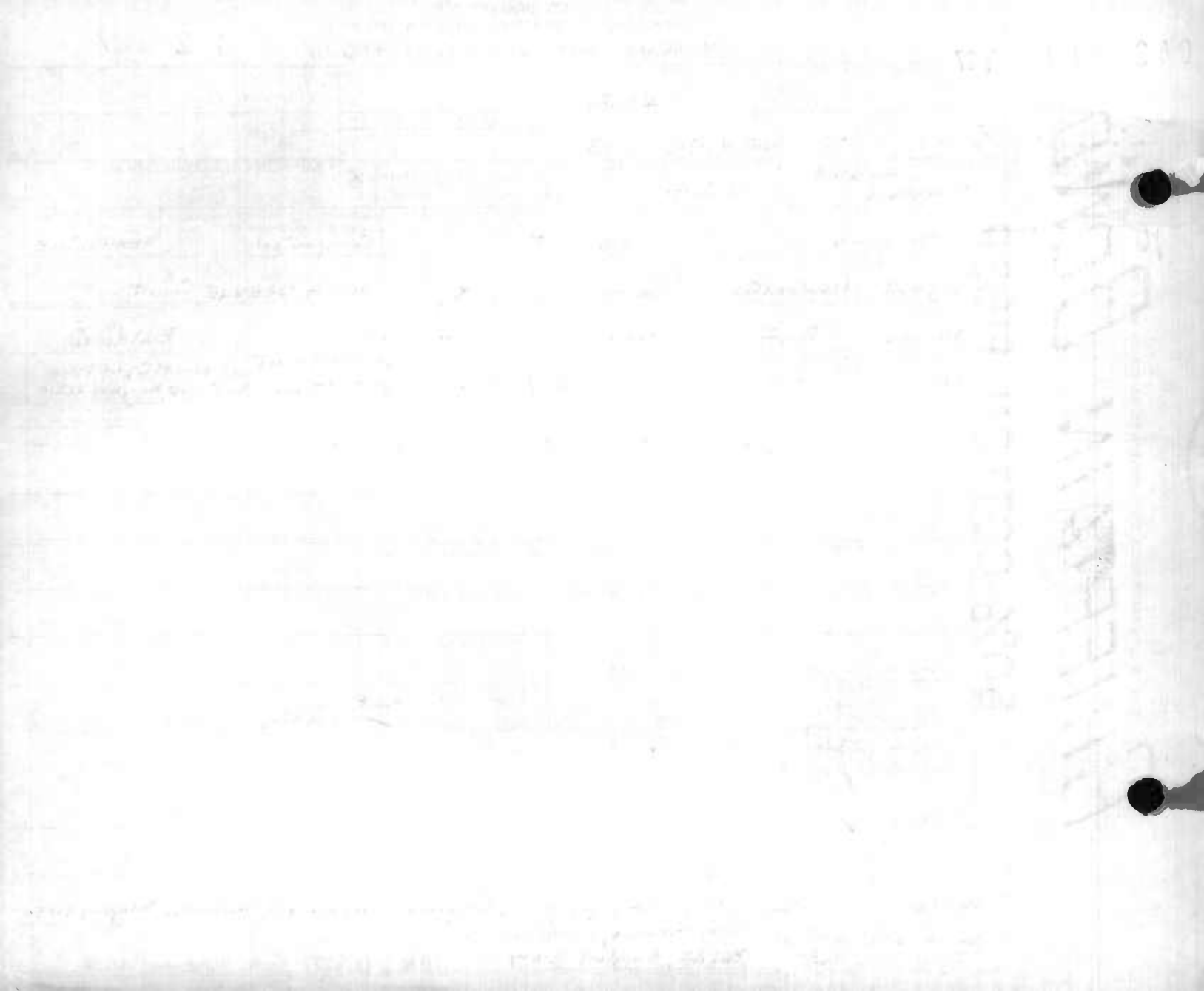
REG. NO. 02177

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	7a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	7b. HOUR	
DOROTHY Baldwin STREETT					DATE MATED <input checked="" type="checkbox"/>		1	25	19 87	M	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		
FEMALE	WHITE	April 4, 1913		73 YRS.					1 25 19 87		
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7e. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Forest Hill Maryland		U.S.A.				Harford County MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bel Air (21014)		108A Seevue Court				Companion		HEALTH CARE			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
13a. STATE		13b. CITY OR TOWN		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		108 A SEEVUE Court 21210			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
James Ruff Streett		Hannah Baldwin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (NAME) ADDRESS							
NO		215-32-4677		(NEPHEW) 467-0415 301 Northfield Place Ms Alexander P. Brown Baltimore, Maryland 21210							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a): Cranio-cerebral trauma											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b):											
DUE TO, OR AS A CONSEQUENCE OF											
(c):											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
			11 P.M. 1-24-1987		Subject fell.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
			home		108A Seevue Court Bel Air, Harford MD						
22a. I certify that full charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE					TITLE (SPECIFY)			DATE SIGNED			
Charles P. Kokes, M.D.					M.D. Assistant MEDICAL EXAMINER			1-26-87			
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS						
Charles P. Kokes, M.D.					111 Penn St., Balto., MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			JAN. 29, 1987		Rock Spring Episc. Cemetery			Forest Hill, Harford Co., Maryland 21050			
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Joseph William Foster 50 W. Broadway & Williams St Bel Air, Maryland 21014					JAN 29 1987			Julia Davidson-Randall			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE SUBMITTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF OF THE MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BASIS FOR PREPARING THE TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 7 and 8 should be detached for use on the burial-transit permit. These pages remain the property of the State Department of Health and Mental Hygiene and should be returned with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic agent, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 02178 REG. NO.	
1- FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH du VERNETT TAPLEY						January 31, 1987				7:30 P <sub>M</sub>	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 31, 1897		6 AGE (IN YEARS LAST BIRTHDAY) 90		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10 CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12 Lake Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS / ZIP CODE					
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		12 Lake Drive		21014	
14 FATHER'S NAME FIRST MIDDLE LAST Alan --- Dibblee						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria --- Ellegood					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no						16b. SOCIAL SECURITY NO. 212-74-3687		17. INFORMANT ADDRESS John R. Tapley, 1004 Leeswoods Road, Bel Air, Md. 21014			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ADENOCARCINOMA BOWEL &amp; METASTASES</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 10, 19 87</u> to <u>JAN 31, 19 87</u> , that (I) (we) last saw the deceased alive on <u>JAN 10, 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Philip W. Heuman</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-1-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip W. Heuman, M.D.						22e. ADDRESS 307 Hickory Ave., Bel Air, Md. 21014					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Feb. 1, 1987		23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE W. Chester Chester Pa.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009						25a. DATE OF DEATH BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 09 1987 Julia Davidson-Randall					

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FEB 02 1981



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 02177  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Billy Joe Taylor</b>			2a DATE OF DEATH MONTH DAY YEAR <b>January 13, 1987</b>		2b HOUR <b>6:30 PM</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>March 27 1950</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>36</b> YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b CITIZEN OF WHAT COUNTRY? <b>United States</b>		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County, MD.</b>				
10 CITY OR TOWN OF DEATH <b>Forest Hill</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2313 Ady Road</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Assembly Line Oper.</b>		
12b KIND OF BUSINESS OR INDUSTRY <b>Automotive</b>						
13a STATE <b>Maryland</b>		13b COUNTY <b>Harford</b>		13c CITY OR TOWN <b>Forest Hill</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ralph Parthree</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mildred Taylor</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		
16b SOCIAL SECURITY NO. <b>212-48-6147</b>		17 INFORMANT ADDRESS <b>Forest Hill, MD</b> <b>Freda Darlene Taylor 2313 Ady Road</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiomyopathy</b> <b>Aust</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced Cancer of Lung + Liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral Arteriosclerosis 20 to 30% to Heart</b> Approximate Interval Between Onset and Death <b>2 months</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Cachexia</b>						
19a DATE OF OPERATION <b>1/13/87</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>not applicable</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>8 Law Street Aberdeen, MD 21001</b>		
22 I certify that (I) (this hospital) attended the deceased from <b>1/13/87</b> to <b>1/13/87</b> , that (I) (we) last saw the deceased alive on <b>1/13/87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <b>mmf</b>		DEGREE <b>MD</b>		22c DATE SIGNED <b>1/15/87</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Manuel Lazatin, M.D.</b>		22e ADDRESS <b>8 Law Street Aberdeen, MD 21001</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>1/17/87</b>		23c NAME OF CEMETERY OR CREMATORY <b>Welcome Home Cemetery</b>		
23d LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air Harford MD</b>						
24 FUNERAL DIRECTOR NAME ADDRESS <b>John Harkins 600 Main Street Delta, PA 17314</b>				25a DATE REC'D. BY REGISTRAR <b>JAN 20 1987</b>		
				25b REGISTRAR'S SIGNATURE		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02130  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GRACE LYVONNE Taylor			2a. DATE OF DEATH MONTH DAY YEAR 1-5-87		2b. HOUR 8 A M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-04-14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own home			
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN STREET		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3527 Miller Rd 21154			
14. FATHER'S NAME FIRST MIDDLE LAST John Wyatt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melissa Baldwin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-82-5834		17. INFORMANT ADDRESS Lacy Taylor 3529 Miller Road Street, MD 21154					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>1/4</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Panayiotis L. Sitaras</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/5/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PANAYIOTIS L. SITARAS				22e. ADDRESS 1814 BELAIR RD Fallston Md 21154							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/8/87		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford MD			
24. FUNERAL DIRECTOR NAME John H. Harkins				ADDRESS 600 Main Street Delta, PA 17314				DATE REC'D. BY REGISTRAR JAN 9 1987			
				REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical officer of health should be notified.

MEDICAL CERTIFICATION

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040932 JAN 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02181

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF DEATH			2c. DATE PRONOUNCED DEAD			2d. HOUR		
Frank Michael Thomas			1/13 1987			1/13 1987			2:00 a.m.			2:00 a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		
M	W	10 07 22	64 YRS.			Harford			Fallston			Fallston General Hospital		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
Maryland			USA						Harford			Fallston		
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13. CITY OR TOWN			14. INSIDE CITY LIMITS?			15. STREET ADDRESS			16. KIND OF BUSINESS OR INDUSTRY		
PA			York			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RD#3 Box 347A Hilltop Rd.			Steel		
17. FATHER'S NAME			18. MOTHER'S MAIDEN NAME			19. INFORMANT			20. ADDRESS			21. SOCIAL SECURITY NO.		
John E. Thomas			Maryann Temko			John Thomas (son)			same			214 18 2068		
22. WAS DECEASED EVER IN U.S. ARMED FORCES?			23. SOCIAL SECURITY NO.			24. INFORMANT			25. ADDRESS			26. SOCIAL SECURITY NO.		
Yes			WW 2			John Thomas (son)			same			214 18 2068		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>CORONARY HEART DISEASE</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.														
(b) <u>ASCVD</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
				P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION						
								CITY OR TOWN COUNTY STATE						
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED						
Luis E. Renjel, MD				Deputy				1/13/87						
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				DATE REC'D. BY REGISTRAR						
Luis E. Renjel, MD				464 Alliance St. Havre De Grace, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY						
Cremation				1/15/87				Yorktowne Crematory						
23d. LOCATION				23e. COUNTY				23f. STATE						
York				York				Penna						
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
John H. Harkins				600 Main St., Delta, Penna				JAN 16 1987						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

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WILLIAM

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

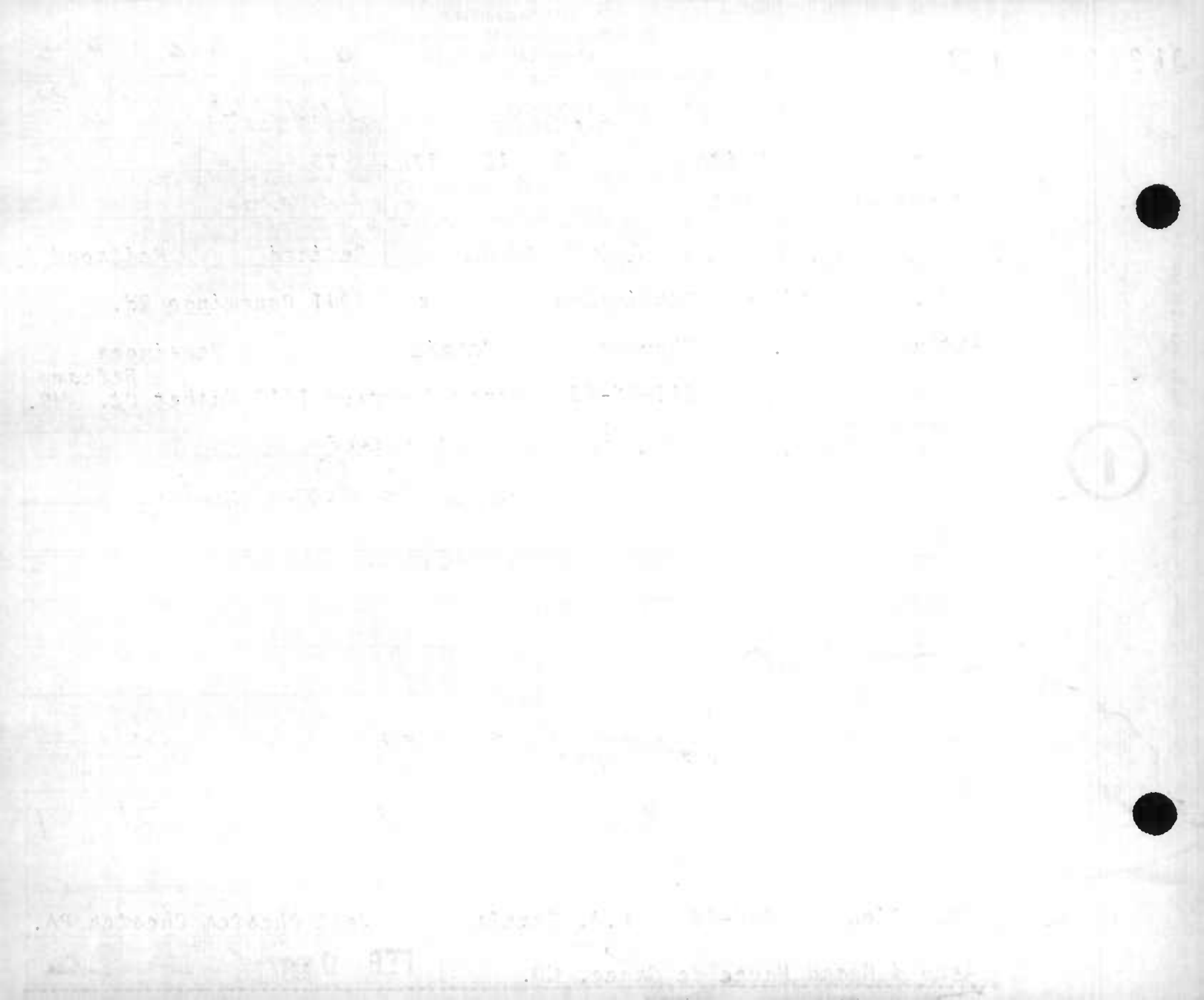
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the yellow papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 02182	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Frederick A. Thompson</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>JANUARY 31 1987</i>			2b. HOUR <i>11 P M</i>			
3. SEX <i>male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 12 13</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>73</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Hartford</i> MD.					
10. CITY OR TOWN OF DEATH <i>HAVRE DE GRACE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hartford Mem Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MD.</i>		13b. COUNTY <i>Hartford</i>		13c. CITY OR TOWN <i>Darlington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>4041 Conowingo Rd. 21034</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Arthur E. Thompson</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Carrie Pensinger</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>215-03-1602</i>		17. INFORMANT ADDRESS <i>Nancy Thompson 1213 Musket Ct. MD. Belcamp</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ischemic cardiomyopathy</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>1-28</i> 19 <i>87</i> to <i>1-31</i> 19 <i>87</i> , that (I) (we) lost the deceased above on <i>1-31</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Bruce T. Gordon M.D.</i>				DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/1/87</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>2-4-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>R.A. Ferris</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>West Chester Chester PA.</i>					
24. FUNERAL DIRECTOR NAME <i>Arnold Beard Havre de Grace, MD.</i>				ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>FEB 9 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 02185  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (PRINT)			2a. DATE OF DEATH			2b. HOUR		
Margaret ANN Tiller			Jan. 18, 1987			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female	white	MONTH DAY YEAR 1 8 36	51 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
W. Virginia	USA				Harford MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Harford	Harford Memorial Hospital			Waitress				
13a. STATE			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS		
Md.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			458 Harrisville Rd. 21917		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			ADDRESS		
Gilbert Lee Gleason			Vanna Hash			10500 Limestone Road		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
No			n/a			Harvey L Tiller Oxford, PA 19363		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SHOCK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>POSSIBLE PULMONARY EMBOLISM</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 HOURS 8 HOURS								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1-17, 1987, to 1-17, 1987, that (I) (we) last saw the deceased alive on 1-17, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
Charles R. Eck, Jr.						MD		1/12/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
Charles R. Eck, Jr.						223 W. Bel Air Ave Aberdeen MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			1-21-87		Calvary Baptist		Rising Sun Cecil MD	
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
R.T. Foard Funeral Home Rising Sun, MD						JAN 27 1987		Julia Tiller

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file them with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must be notified or called.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 02184

1. DECEASED NAME (TYPE OR PRINT) Tipton Russell Bannon			2a. DATE OF DEATH MONTH DAY YEAR 01 06 87			2b. HOUR 0840 AM				
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 11 10 40		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.				
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rural Carrier		12b. KIND OF BUSINESS OR INDUSTRY U.S. Postal Service		
13a. STATE Maryland		13b. CITY OR TOWN Port Deposit		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 617 Principio Rd.		21904		
14. FATHER'S NAME FIRST MIDDLE LAST Russell Boyd Tipton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen L. Bannon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 220-40-9033		17. INFORMANT Sharon M. Tipton				Port Deposit, Md. 21904	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fulminant hepatic failure DUE TO, OR AS A CONSEQUENCE OF (b) Non-A, non-B hepatitis DUE TO, OR AS A CONSEQUENCE OF (c) Esophageal carcinoma for esophageal CA VOID PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Metastatic esophageal carcinoma									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. 7 wk. 6 weeks	
19a. DATE OF OPERATION none			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N.A.			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N.A.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N.A.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> N.A.			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N.A.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N.A.					
22a. I certify that (I) (this hospital) attended the deceased from 1-4-87, 19____, to 1-6-87, 19____, that (I) (we) last saw the deceased alive on 1-6-87, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Andrew P. Fridberg MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/6/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW PAUL FRIDBERG			22e. ADDRESS 502 LEWIS ST. HAVRE DE GRACE, MD. 21078							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 8, 1987		23c. NAME OF CEMETERY OR CREMATORY St. Mark's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Perryville Cecil Maryland			
24. FUNERAL DIRECTOR Lee A. Patterson & Son			ADDRESS Perryville, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 9 1987		25b. REGISTRAR'S SIGNATURE A. H. Anderson-Pendall			

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, or medical examination must be certified by a doctor.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div> <div>043498</div> <div>043498</div> </div>									
<div> <div>FOR STATE REGISTRAR</div> <div>REG. NO. 8702185</div> </div>									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		2b. HOUR		3. SEX
FRANCES D. VALLE					1 31 87		6 57 P M		Female
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
Female		White		June 6 1916		70 YRS		Penna.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Penna.		U.S.A.				Harford COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
Fallston		Fallston Gen. Hosp.							
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
HOMEMAKER									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MD.		Baltimore		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6 AIRWAY CIRCLE APT. 1A 21204	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
GAETANO LaPONZINA					FRANCESCA LOMBARDO				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					213-05-0282		Baldwin Md. PAUL VALLE (SON) 9 PALMWAY COURT		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anoxic Encephalopathy</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiorespiratory Arrest</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Myocardial Infarction / Pulmonary Contusion / Rib Fractures</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. ALTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
1/29/87		<u>Exploratory Laparotomy, Splenectomy, Left Hemicolectomy / Sigmoidectomy</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death.)									
22b. SIGNATURE					22c. ADDRESS				
<u>George LAWS M.D.</u>					<u>Chav. day Dr. Smith</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
George LAWS M.D.					Chav. day Dr. Smith				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL		2/4/87		Dulaney Valley		Baltimore COUNTY Md. STATE			
24. FUNERAL DIRECTOR					25a. BY REGISTRAR				
SCHIMUNEK FUNERAL HOME, INC.					FEB 6 1987				
NAME 9705 Belair Rd., Balto. Md. 21236					25b. REGISTRAR'S SIGNATURE				
					<u>John Schimunek</u>				

10-2-40  
10-2-40

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The number of the...  
is the...

10-2-40  
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041162 JAN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 02100

REG. NO.

FOR STATE REGISTRAR (Loretta Vernal VanderPluym)

87 02100

1. DECEASED NAME (TYPE OR PRINT) <b>Loretta VERNELL Van Der Pluym</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01-11-87</b>		2b. HOUR <b>2 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>08 22 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Hanford</b> MD.	
10. CITY OR TOWN OF DEATH <b>Fallston</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BOOKKEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>Hanford</b>	13c. CITY OR TOWN <b>Bel Air</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>JOSEPH</b> LAST <b>SELLERS</b>		15. MOTHER'S MAIDEN NAME FIRST <b>VPDA</b> MIDDLE <b>SCHUETTE</b> LAST <b>SCHUETTE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>325-14-9889-A</b>		17. INFORMANT (Husband) <b>879-8815</b> ADDRESS <b>1111 Oak Ridge Court Mr. Richard H. VanderPluym Bel Air Maryland 21014</b>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Status Asthmaticus with Respiratory Dec. 19, 86</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Bronchial asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Life long history</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOME <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 19, 1986</b> to <b>Jan 11, 1987</b> that (I) (we) last saw the deceased alive on <b>Jan 10, 1987</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <b>Albert S. C. Sun, M.D.</b>		DEGREE <b>M.D.</b>		DATE SIGNED <b>Jan 11, 87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Albert S. C. Sun, M.D.</b>		22e. ADDRESS <b>1800 Hanford Rd. Fallston 21047</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Jan. 14, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		24. FUNERAL DIRECTOR <b>Joseph William Foster</b> <b>50 W. Broadway &amp; Williams St.</b> <b>Bel Air, Maryland 21014</b>			
25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Friedman-Rubins</b>			

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial or cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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042164 JAN 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 02187  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Aslaug (nmn) Vikestad</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1-24-87</b>		2b. HOUR <b>11:47p M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-05-03</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oslo, Norway</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS	
11. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Citizens Nursing Home</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b> MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Churchville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Christian -- Johansen</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helga -- (unknown)</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>082-20-1117</b>		17. INFORMANT ADDRESS <b>Churchville, Md. 21028</b> <b>Walter S. Vikestad, 3007 Rolling Green Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pneumonia, Dehydration</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>E.M. Camacho MD</b>		DEGREE		22c. DATE SIGNED <b>1/25/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E.M. CAMACHO MD</b>		22e. ADDRESS <b>131 S. UNION AVE. Haverhill, MA</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Cremation</b>		23b. DATE <b>Jan. 25, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>R.A. Ferris Crematory</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Howard K. McComas III, Abingdon, Md. 21009</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>W. Chester Chester Pa.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1987</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the State Dept. of Health and Mental Hygiene prior to burial. (Important: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.)

11:11

1-2-57

1-2-57

1-2-57

11:11

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1-2-57

042397 JAN 19 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, condition, or traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 02183		
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR		
John Kenneth Voit					January 19, 1987					9:58 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Feb. 23 1918			68		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA		WIDOWED		DIVORCED		Harford County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY				
Havre de Grace		Harford Memorial Hospital				Executive		Infection Control Specialist				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		13f. STREET ADDRESS / ZIP CODE		
Maryland		Harford		Havre de Grace		YES NO X		1036 Chesapeake Drive Apt 9B		21078		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME							
Lawrence E. Voit					Sarah Barry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.		17. INFORMANT					
No					215-05-3080		Mrs. Hermina G. Voit, 1036 Chesapeake Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 21078 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION 1 HOUR DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RECENT ACUTE MYOCARDIAL INFARCTION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES X NO		YES NO X		
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED								
OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2								
(IF EITHER NOTIFY MEDICAL EXAMINER)		P.M. 19										
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION								
WHILE AT WORK NOT WHILE AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE					DEGREE					22c. DATE SIGNED		
C. Eck					MD					1/24/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS							
CHARLES R. ECK JR					223 W. BELAIR AVE, ABERDEEN, MD							
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION				
Burial			1/22/87		Dulaney Valley Mem. Car.			Timonium Balto Md.				
24. FUNERAL DIRECTOR					25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
NAME Martin D. Lawson					JAN 29 1987			John P. ...				
10 W. Padonia RD.												



042160 JAN 29 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 02189

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	MIN.	
Lillian M. Wainwright					1	21	87				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female	Black	5 MONTH 30 DAY 09 YEAR		77 YRS.		MONTHS		DAYS		MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	USA			Baltimore City Harbor MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore	Residence										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE						
Maryland	Harford	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		402 Pulaski Hwy. Joppa Md. (21085)						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)							
George		Mary		No							
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
217-07-3072		Crystal R. Scott		(Same)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>met. Colon Carcinoma</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN, COUNTY, STATE							
22. I certify that (I) (this hospital) attended the deceased from <u>5-12-1986</u> to <u>1-21-1987</u> that (I) (we) last saw the deceased alive on <u>12-16-1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
<u>Murli N. Mathur</u>		M.D.		1-21-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Murli N. Mathur, M.D.		1305 Fallston Road Fallston, MD 21047									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY STATE			
Burial		1/24/87		Memorial Gardens		Belair		Md.			
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Wm C March F/H West		4300 Wabash Ave.		JAN 27 1987		<u>Julia Denton</u>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified.

1

RECEIVED

100

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

3. SEX

4. RACE

5. DATE OF BIRTH

MONTH

DAY

YEAR

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17. INFORMANT

ADDRESS

NO

206-12-0331

SHELBY FAIR, 408 MARKET ST., HAVRE DE GRACE, MD 21078

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) STROKE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Chronic Obstructive Lung Disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from 12-24, 1986, to JAN 15, 1987, that (I) (we) last saw the deceased alive on JAN 15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

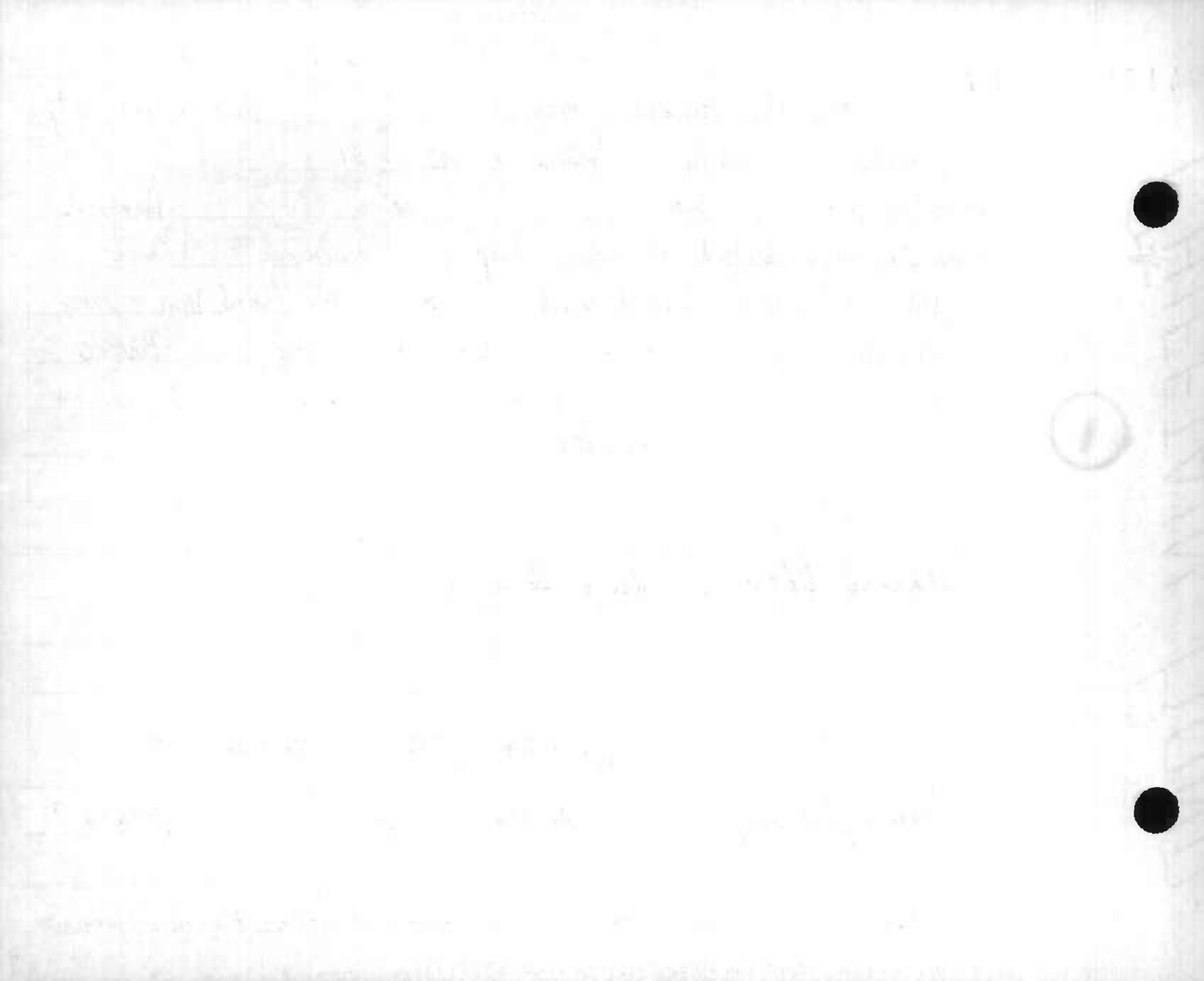
NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

TARRING FUNERAL HOME, P.A., ABERDEEN, MD. 21001-3399

JAN 21 1987





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as "I", it shows only injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 02191	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CATHERINE ELIZABETH WILLICK						2a. DATE OF DEATH MONTH DAY YEAR January 15, 1987		2b. HOUR 1:30 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Edgewood		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1805 Nuttall Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1805 Nuttall Ave. 21040	
14. FATHER'S NAME FIRST MIDDLE LAST Henry -- Albert				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna -- Sadler				16. ADDRESS Md. 21040			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT Charles J. Willick, 1805 Nuttall Ave, Edgewood					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HAS APO</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>---</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DEGREE John D. Yun MD 22b. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Yun								22c. DATE SIGNED 1-15-87		22d. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. ADDRESS Home de Grace, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 17, 1987		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009								25a. DATE REC'D. BY REGISTRAR JAN 18 1987		25b. REGISTRAR'S SIGNATURE Julia Tinsley	

My dear Mr. Garrison  
I have just received  
your letter of the 10th inst.

1851

I am very glad to hear  
of your success in your  
cause.

042678 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top portion of this certificate, pages 1 and 2, and file them within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic cause, the medical examiner should be notified if one.

## MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL / CREMATION</b>	23b. DATE <b>1/29/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>R.A. FERRIS &amp; Co.</b>	23d. LOCATION CITY OR TOWN <b>WEST CHESTER</b> COUNTY <b>CHESTER</b> STATE <b>PENNA.</b>
24. FUNERAL DIRECTOR NAME <b>TAPPING FUNERAL HOME, P.A., ABERDEEN, MD.</b> ADDRESS <b>21001-3399</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1987</b> 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodman</i>	

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 02192  
REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 28, 1987</b>		2b. HOUR <b>5:15 A.M.</b>		
3. DECEASED NAME (TYPE OR PRINT) FIRST <b>JOHN</b> MIDDLE <b>BOND</b> LAST <b>WYSONG</b>			4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 20, 1903</b>		
6. SEX <b>MALE</b>			7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b>		MD.		
10. CITY OR TOWN OF DEATH <b>DARLINGTON</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2001 GLENVILLE ROAD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CIVIL ENGINEER</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>			13a. STREET ADDRESS / ZIP CODE <b>2001 GLENVILLE ROAD / 21034</b>				
13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13c. STREET ADDRESS / ZIP CODE <b>2001 GLENVILLE ROAD / 21034</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN BOND WYSONG</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELLA GRAYMES</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>212-18-9926</b>		17. INFORMANT ADDRESS <b>MARTHA A. WYSONG, SAME AS ABOVE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Phnumonia</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 27, 1987</b> to <b>Jan 27, 1987</b> , that (I) (we) last saw the deceased alive on <b>Jan 27, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dante Monnik</i>		DEGREE		22c. DATE SIGNED <b>1/28/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANTE MONNIK</b>		22e. ADDRESS <b>Hartford, Md 21078</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 4B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
<div style="text-align: right;">00-56-18 87 02193 REG. NO.</div>										
1. DECEASED NAME (TYPE OR PRINT) <b>VITOLD LEO ZYNEL</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 12 87</b>			2b. HOUR <b>7:15 A</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 27, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.				
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Meat Cutter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US-govt. Ret.</b>		
13a. STATE <b>Maryland</b>					13b. CITY OR TOWN <b>Harford</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>501 King Arthur Court 21014</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph -- Zynel</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Patricia Gorski</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII 182-16-5894</b>		17. INFORMANT ADDRESS <b>Bel Air, Md. 21014</b> <b>Patricia A. Zynel, 501 King Arthur Court</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rheumatic Heart disease</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/12/87</b> to <b>1/12/87</b> , that (I) (we) last saw the deceased alive on <b>1/12/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Daunte Monakil</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/12/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAUNTE MONAKIL</b>					22e. ADDRESS <b>Harre De Grace Md 21078</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 14, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens, Bel Air Harford Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III, Abingdon, Md. 21009</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Lindon-Rudness</b>			

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